HENDRICKSON
CHIROPRACTIC &
WELLNESS CENTER

PERSONAL INJURY QUESTIONNAIRE Date:_____

Name: _____ Phone: ( ) _____
Address: _____ City: _____ State: _____ Zip: _____
Age: _____ Birthdate:_____ Sex: _____ S/S #: _____
Employer's Name: _____ Employer's Address: _____
Your Ins. Co: _____ Policy #: _____ Agent's Name: _____
Name on Policy (If other than self): _____ Policy #: _____
Responsible Party's Name: _____
Address: _____ City: _____ State: _____ Zip: _____
Policy Holder's Name: _____ Policy #: _____

ATTORNEY
Name: _____ Phone: ( ) _____
Address: _____ City: _____ State: _____ Zip: _____
Were there any Witnesses? ( ) Yes ( ) No Name(s): _____

NATURE OF ACCIDENT

1. Date of Accident: _____ Time of Day: _____
2. Were you: ( ) Driver ( ) Passenger ( ) Front Seat ( ) Back Seat
3. Number of people in your vehicle: _____ Were you wearing seat belts? _____
4. What direction were you headed? ( ) North ( ) South ( ) East ( ) West
   on (name of street):_____
5. What direction was other vehicle headed? ( ) North ( ) South ( ) East ( ) West
   on (name of street):_____
6. Were you struck from: ( ) Behind ( ) Front ( ) Left Side ( ) Right Side
7. Approximate speed of your car _____mph; Other car_____mph
8. Were you knocked unconscious? ( ) Yes ( ) No If yes, for how long? _____
9. Were police notified? ( ) Yes ( ) No
10. In your own words, please describe accident: _____
    _____
    _____
    _____
11. Did you have any physical complaints BEFORE THE ACCIDENT? ( ) Yes ( ) No If yes, describe in detail:
    _____
    _____
    _____
12. Please describe how you felt:
    a. DURING the accident: _____
    b. IMMEDIATELY AFTER the accident: _____
    c. LATER THAT DAY: _____
    d. THE NEXT DAY: _____

13. What are your PRESENT complaints and symptoms? _____
_____
_____

14. Do you have any congenital (from birth) factors which relate to this problem? ( ) Yes ( ) No
If yes, describe: _____
_____

15. Do you have any previous illnesses which relate to this case? ( ) Yes ( ) No
If yes, describe: _____
_____

16. Have you been involved in an accident before? ( ) Yes ( ) No If yes, describe, including dates and types of accidents, as well as injury(ies) received: _____
_____
_____

17. Where were you taken after the accident? _____

18. Have you been treated by another doctor since the accident? ( ) Yes ( ) No If yes, list doctor's name & address: _____
What type of treatment did you receive? _____
_____

19. Since this Injury occurred, are you symptoms: ( ) Improving ( ) Getting Worse ( ) Same

20. CHECK SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT:

☐ Headache	☐ Irritability	☐ Numbness in Toes	☐ Face Flushed	☐ Feet Cold
☐ Neck Pain	☐ Chest Pain	☐ Shortness of Breath	☐ Buzzing in Ears	☐ Hands Cold
☐ Neck Stiff	☐ Dizziness	☐ Fatigue	☐ Loss if Balance	☐ Stomach Upset
☐ Sleep Probs	☐ Head Seems Heavy	☐ Depression	☐ Fainting	☐ Constipation
☐ Back Pain	☐ Pins/Needles in Arms	☐ Lights Bother Eyes	☐ Loss of Smell	☐ Cold Sweats
☐ Nervousness	☐ Pins/Needles in Legs	☐ Loss of Memory	☐ Loss of Taste	☐ Fever
☐ Tension	☐ Numbness in Fingers	☐ Ears Ring	☐ Diarrhea	☐ _____

Symptoms other than above: _____

21. Have you lost time from work as a result of this accident? ( ) Yes ( ) No If yes, please complete:
a. Last Day Worked: _____
b. Type of Employment: _____
c. Present Salary: _____
d. Are you being compensated for time lost from work? ( ) Yes ( ) No If yes, state type of compensation you are receiving: _____

22. Do you notice any activity restrictions as a result of this injury? ( ) Yes ( ) No If yes, please describe:
_____
_____
_____

23. Other pertinent information: _____
_____
_____
_____

Date: _____ Patient Signature: _____