Print Form

Personal Injury Questionnaire

ShephardClinic of The Chiropractic Arts

Name _____ Date of accident: _____
First Middle inital Last

Type of incident? ☐ auto ☐ pedestrian ☐ motorcycle ☐ bicycle ☐ slip & fall Time of accident: _____ ☐am ☐pm

Were you a : ☐ driver ☐ passenger If you you were a passenger, what position in the vehicle?_____ Make, model & yr? _____

If it was an auto collision, were you struck from: ☐ behind ☐ right side ☐ left side ☐ head-on Make, model & year of 2nd vehicle?_____

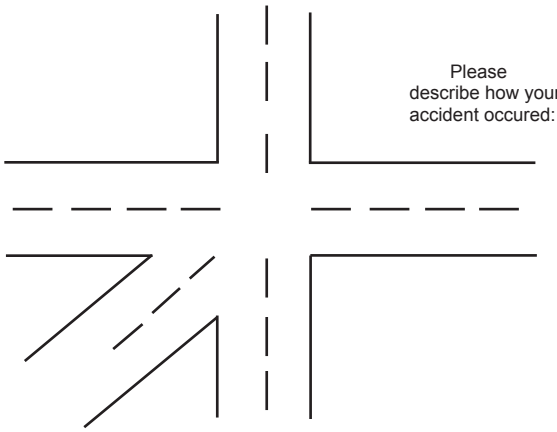
Please draw a sketch of the collsion on the street diagram below. Were you hit or did you hit someone else? ☐ I was struck ☐ I struck someone/thing else

Were you wearing a lap belt? ☐YES ☐NO Shoulder harness? ☐YES ☐NO head rest? ☐YES ☐NO Did air bag deploy? ☐YES ☐NO

If shoulder restraint was in use, was it a: ☐ shoulder-lap combination ☐ harness only If there were any other people in your vehicle, please list them here:

_____

_____



Please describe how your accident occured: _____

_____

_____

At impact, were you looking to the: ☐ right ☐ left ☐ straight ahead

Were your hands on the steering wheel? ☐YES ☐NO

Was your foot depressing the brake pedal? ☐YES ☐NO

Did you have a chance to brace for impact? ☐YES ☐NO

Did your body strike anything inside the vehicle at impact? ☐YES ☐NO

If you answered yes, please describe:_____

Immediately following the accident, did you have any physical complaints? ☐YES ☐ NO If yes, please describe:_____

_____

Were you unconscious? ☐YES ☐NO If yes, for how long?_____ Was emergency care provided on-site? ☐YES ☐NO

Were you transported by ambulance or other emergency vehicle? ☐YES ☐ NO If yes, by whom?_____

If no, did you eventually get emergency room care? ☐ YES ☐ NO If so, at what hospital? _____

Were X-rays taken? ☐YES ☐ NO Of what body parts: _____ Attending doctor's name: _____

His/her diagnosis:_____ Treatment rendered: _____ Medications prescribed?_____

Released same day? ☐YES ☐NO Recommendations/home care? _____

Did any new symptoms develop in the week following the accident? ☐YES ☐NO If so, describe: _____

If you have consulted another Doctor, give full name and address: _____

Since this accident, are your symptoms ☐ the same ☐ better ☐ worse?

BRIEFLY DESCRIBE YOUR SYMPTOMS _____

_____

_____

☐ any radiating pains ☐ numbness ☐ weakness ☐ knee, ankle or foot pain ☐ jaw pain ☐ pain w/ chewing or swallowing ☐ head pain?

Any other complaints or difficulties as a result of your injury?_____

Have you retained or consulted with an attorney as a result of your injuries sustained? ☐YES ☐NO name: _____

patient signature _____ **date** _____

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