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PATIENT INFORMATION FORM – PERSONAL INJURY QUESTIONNAIRE (Page 1 of 3)

DATE: _____ PATIENT NAME: _____

Your Auto Insurance Company:_____ Claim #:_____

Adjusters Name:_____ Adjusters Phone #:_____

1. Date of Accident: _____ Time of Day: _____

2. Number of vehicles involved in the accident? _____

3. What direction were you headed? □ North □ East □ South □ West, **on (name of street & city):** _____

4. What direction was the other vehicle headed? □ North □ East □ South □ West, **on (name of street & city):** _____
_____

5. Were you struck from: □ Behind □ Front □ Left Side □ Right Side

6. What did your vehicle do immediately after the accident? □ hit a guardrail □ hit a tree □ rolled over □ was run off the road □ other
_____

7. Were you the: □ Driver □ Passenger, Sitting in the: □ Front Seat □ Back Seat

8. Number of people in your vehicle? _____ Other vehicle: _____

9. Were the police notified? □ No □ Yes 10. In your own words, please describe the accident:_____

_____

_____

_____

11. Did you know the accident was coming? □ No □ Yes 12. What type of vehicle were you in? _____

13. What type of vehicle impacted yours? _____

14. At the time of impact, your vehicle was? □ slowing down □ stopped □ gaining speed □ moving at a steady speed
At what mph?_____

15. At the time of impact, the other vehicle was? □ slowing down □ stopped □ gaining speed □ moving at a steady speed
At what mph?_____

16. During and after the crash what happened to your vehicle? (circle all that apply)
-kept going straight - spun around - other _____
- kept going straight hitting a car in front - spun around and hit a stationary object
- was hit by another vehicle - hit a stationary object

17. Did you lose consciousness during the accident? □ No □ Yes

18. How was your head positioned during the accident? □ Forward □ Back □ Turned to the Left □ Turned to the Right

19. How was your torso positioned during the accident? □ Forward □ Back □ Turned to the Left □ Turned to the Right

20. How were your hands positioned during the accident? □ Left hand on steering wheel □Right hand on steering wheel □ Both hands on steering wheel □ Bracing yourself □ Other _____

21. Did your head hit anything during the accident? □ No □ Yes, if yes what: _____

22. Did your face hit anything during the accident? □ No □ Yes, if yes what: _____

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23. Did your shoulders hit anything during the accident? □ No □ Yes, if yes what: _____

24. Did your neck hit anything during the accident? □ No □ Yes, if yes what: _____

25. Did your chest hit anything during the accident? □ No □ Yes, if yes what: _____

26. Did your hips hit anything during the accident? □ No □ Yes, if yes what: _____

27. Did your knees hit anything during the accident? □ No □ Yes, if yes what: _____

28. Did your feet hit anything during the accident? □ No □ Yes, if yes what: _____

29. What kind of headrest was in your vehicle?
□ Movable fixed headrest □ Non-movable fixed headrest □ No headrest

30. Where was the headrest positioned on your head? □ Back of your head □ Below the head □ Other _____

31. Did you have your seatbelt on during the accident? □ No □ Yes

32. Did you slide out of your seatbelt during the accident? □ No □ Yes □ Partially slid out

33. What was damaged in your vehicle? (check all that apply)

□ windshield	□ rear bumper	□ mirror
□ steering wheel	□ front bumper	□ knee bolster
□ dashboard	□ trunk	□ back right door
□ seat frame	□ front left door	□ completely totaled
□ side window	□ front right door	
□ rear window	□ back left door	

34. Choose items that dented inward.
□ floorboards □ side doors □ dashboard □ Nothing □ Other _____

35. Choose the doors that would not open as a result of the accident.
□ front left □ front right □ Not applicable
□ rear left □ rear right

36. Did you go to the hospital? If no, why and do not answer 38-43. _____

37. How did you get to the hospital?
□ Drove self □ Ambulance □Other_____

38. What was the name of the hospital? _____

39. Were you hospitalized overnight? □ No □ Yes

40. Select what you were prescribed at the hospital.
□ pain medication □ muscle relaxers □ neck brace □ other _____

41. Did you receive any stitches for any cuts at the hospital? □ No □ Yes

42. Were x-rays taken at the hospital? □ No □ Yes

43. Have you been treated by another doctor since the accident? □ Yes □ No If yes, please list doctor's name and address:

_____

What type of treatment did you receive?_____

_____

_____

DATE: _____ PATIENT NAME: _____

44. Since the injury occurred, are your symptoms: □ Improving □ Getting Worse □ Staying the Same

45. Did you have any physical complaints BEFORE THE ACCIDENT? □ Yes □ No If yes, please describe in detail:

_____

_____

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

_____

47. Do you have any previous illnesses which relate to this case? □ Yes □ No If yes, please describe: _____

_____

_____

48. Have you ever been involved in an accident before? □ Yes □ No, If yes, please describe, including date(s) and type(s) of accidents, as well as injury(ies) received: _____

_____

_____

49. Have you lost time from work as a result of this accident? □ Yes □ No If yes, please complete the following:

a. Last Day Worked: _____

b. Type of Employment: _____

c. Are you being compensated for time lost from work? □ Yes □ No, Type of compensation: _____

50. Do you notice any activity restrictions as a result of this injury?

_____

_____

51. Other pertinent information:

_____

_____

_____

_____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that the Doctor's office will aid in preparation of any necessary reports and forms to assist me in collection from the insurance company and that amount will be paid directly to Harward Chiropractic which will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand and agree that if I suspend or terminate my care and treatment, any fees for professional services rendered will be immediately due and payable.

I hereby authorize the Doctor to examine and treat my condition as he deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. It is understood and agreed the amount paid the Doctor for x-rays is for examination only and the x-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis.

Patient's Signature: _____ Date: _____