NATIONAL PIKE CHIROPRACTIC -- PERSONAL INJURY QUESTIONNAIRE

NAME: ________________________ HOME PHONE: ______________ CELL PHONE: ______________

ADDRESS: ______________________ CITY: ______________ STATE:______ ZIP: ______________

DATE OF BIRTH: __________ SEX: M F SS #________________ EMPLOYER'S NAME: ______________

EMPLOYER'S ADDRESS: ____

INS CO NAME: ________________ POLICY #________________ AGENT'S NAME: ______________

NAME ON INS POLICY OTHER THAN SELF: ______________________ POLICY # ______________

RESPONSIBLE PARTY'S NAME: ____

ADDRESS: ______________________ CITY: ______________ STATE:______ ZIP: ______________

POLICY HOLDERS NAME: ________________________________POLICY # ______________

ATTORNEY NAME: ________________________ PHONE: ______________________

ADDRESS: ______________________ CITY: ______________ STATE:______ ZIP: ______________

WERE THERE ANY WITNESSES? YES NO IF SO, NAMES: ______________________________

NATURE OF ACCIDENT:

DATE OF ACCIDENT: ______________ TIME OF ACCIDENT: ______________

WHERE YOU: DRIVER PASSENGER FRONT SEAT BACK SEAT (PLEASE CIRCLE CORRECT RESPONSE)

NUMBER OF PEOPLE IN VEHICLE: ________ WERE YOU WEARING A SEAT BELTS YES NO

WHAT DIRECTION WERE YOU HEADED: NORTH SOUTH EAST WEST

ON STREET NAME: ____

WHAT DIRECTION WAS THE OTHER VEHICLE HEADED: NORTH SOUTH EAST WEST

ON STREET NAME: ____

WHERE YOU STRUCK FROM: BEHIND FRONT LEFT SIDE RIGHT SIDE

APPROXIMATE SPEED OF YOUR CAR ______MPH OTHER CAR _____MPH

WERE YOU KNOCKED UNCONSCIOUS: YES NO IF YES HOW LONG: ______________________

WERE POLICE NOIFIED: YES NO

IN YOUR OWN WORDS, PLEASE DESCRIBE ACCIDENT: ______________________________

____

____

DID YOU HAVE ANY PHYSICAL COMPLAINTS BEFORE THE ACCIDENT? YES NO IF YES, PLEASE DESCRIBE IN DETAIL:

____

____

PLEASE DESCRIBE HOW YOU FELT:

DURING THE ACCIDENT: ____

IMMEDIATELY AFTER THE ACCIDENT: ____

LATER THAT DAY: ____

THE NEXT DAY: ____

WHAT AR YOUR PRESENT COMPLAINTS AND SYMPTONS: ____

____

____

DO YOU HAVE ANY CONGENIAL (FROM BIRTH) FACTORS WHICH RELATE TO THIS PROBLEM: YES NO IF YES PLEASE DESCRIBE: ____

DO YOU HAVE ANY PREVIOUS ILLNSSES WHICH RELATE TO THIS CASE? YES NO IF, YES PLEASE DESCRIBE: __________

____

____

HAVE YOU EVER BEEN INVOLVED IN AN ACCIDENT BEFORE: YES NO IF YES, PELASE DESCRIBE, INCLUDING DATE AND TYPE OF ACCIDENTS AS WELL AS INJURY (IES) RECEIVED: ____

____

____

WHERE WERE YOU TAKEN AFTER THE ACCIDENT: ____

HAVE YOU BEEN TREATED BY ANOTHER DOCTOR SINCE THE ACCIDENT: YES NO IF YES, PLEASE LIST DOCTORS NAME AND ADDRESS: ____

WHAT TYPE OF TREATMENT DID YOU RECEIVE? ____

____

SINCE THIS INJUIRY OCCURRED, ARE YOUR SYMPTOMS: IMPROVING GETTING WORSE SAME

CHECK THE SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT:

__HEADACHE	__IRRITABLITY	__NUMBNESS IN TOES	__FACE FLUSHED	__FEET COLD
__NECK PAIN	__CHEST PAIN	__SHORTNESS OF BREATH	__BUZZING IN EARS	__HANDS COLD
__NECK STIFF	__DIZZINESS	__FATIGUE	__LOSS OF BALANCE	__DEPRESSION
__STOMACH UPSET	__SLEEPING PROBLEMS	__HEAD TO HEAVY	__FAINTING	__CONSTIPATION
__BACK PAIN	__PINS/NEEDLES IN ARM	__LIGHTS BOTHER EYES	__LOSS OF SMELL	__COLD SWEATS
__NERVOUSNESS	__PINS/NEEDSLES IN LEG	__LOSS OF MEMORY	__LOSS OF TASTE	__FEVER
__TENSION	__NUMBNESS IN FINGERS	__EARS RING	__DIARRHEA	

OTHER SYMPTOMS: ____

HAVE YOU LOST TIME FROM WORK AS A RESULT OF THIS ACCIDENT: YES NO IF YES, PLEASE COMPLETE THIS QUESTIONS: LAST DAY OF WORK _________________________ TYPE OF EMPLOYMENT: ___________________________

PRESENT SALARY: _________________________

ARE YOU BEING COMPENSATED FOR TIME LOST FROM WORK: YES NO IF YES, PLEASE STATE TYPE OF COMPENSATION YOU ARE RECEIVING: ____

DO YOU NOTICE ANY ACTIVITY RESTRICTIONS AS A RESULT OF THIS INJURY: YES NO IF YES PLEASE DESCRIBE,

____

OTHER PERTINENT INFORMATION: ____

DATE: _________________ PATIENT'S SIGNATURE ____