INTEGRATIVE HEALTH CENTER

PERSONAL INJURY QUESTIONNAIRE

INFORMATION ABOUT YOU

Name______________________________________ DOB_____________ Age _______ Sex ( ) M ( ) F
Address ____
City ____________________________ State____________________ Zip _______________________
Home # __________________________ Cell # _______________________ SS# _________________
Employer_______________________________________Position/Duties_________________________
Employer Address ____

YOUR INSURANCE INFO:

Your Ins. Co __________________ Policy # ______________________ Agents name _______________
Name on policy (if other than self) _____________________________
Responsible Party's Name ____
Address ____
City ____________________________ State____________________ Zip _______________________
Claim #: ___________________________________ Name of Adjuster: ____________________
Phone #: __________________________________

INFORMATION ABOUT YOUR ATTORNEY: (if applicable)

Name____ Phone # _______________________
City ____________________________ State____________________ Zip _______________________
Were there any witnesses? ( ) Yes ( ) No Names ____

NATURE OF ACCIDENT:

1. Date of Accident_______________ Location ________________ Time of day _______________
2. Name of street ____
3. Were you: ( ) Driver ( ) Passenger ( ) Front seat ( ) Back seat
4. Number of people in your vehicle? ____________
5. Were you wearing seat belts? ( ) Yes ( ) No
6. What direction were you headed? ( ) North ( ) South ( ) East ( ) West
   On (name of street) ____
7. Direction of other vehicle? ( ) North ( ) South ( ) East ( ) West
   On (name of street) ____
8. Were you struck from ( ) Behind ( ) Front ( ) Left side ( ) Right side
9. Approximate speed of your car ___________ mph type of vehicle ___________________
10. Speed of other car ___________ mph type of vehicle ___________________
11. Were you knocked unconscious? ( ) Yes ( ) No If yes, for how long?___________
12. Were police notified? ( ) Yes ( ) No
13. Were there any witnesses? ( ) Yes ( ) No Names____________________
14. Describe your body position at time of the accident ______________________________________
    ____
    ____
    ____
15. In your own words, please describe the accident _______________________________________
    ____
    ____
    ____

16. Please describe how you felt:

   a. During the accident: ____

b. Immediately after the accident: ____

c. Later that day: ____

d. The next day: ____

17. What are your present complaints and symptoms? __________________________________
____
____

18. Do you have any congenital (from birth) factors related to this problem? ( ) Yes ( ) No
If yes, describe ____
____

19. Do you have any previous illness which relates to this case? ( ) Yes ( ) No
If yes, describe ____
____

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

21. Where were you taken after your current accident? _________________________________
____

22. Have you been treated by another doctor(s) since this accident? ( ) Yes ( ) No
If yes, please give name of doctor and type of treatment received:
i. ______________________________ iii. ______________________________
ii. ______________________________ iv. ______________________________

23. Did you have any physical complaints **before the accident**? ( ) Yes ( ) No
If yes, describe ____
____

24. Since this injury occurred are your symptoms ( ) Improving ( ) Getting worse ( ) Same

25. **CHECK ALL SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT**

( ) headache	( ) irritability	( ) numbness-toes	( ) face flushed	( ) feet cold
( ) neck pain	( ) chest pain	( ) shortness breath	( ) buzzing in ears	( ) hands cold
( ) neck stiff	( ) dizziness	( ) fatigue	( ) loss of balance	( ) stomach upset
( ) sleep prob.	( ) head heavy	( ) depression	( ) fainting	( ) constipation
( ) back pain	( ) pins/needles-arms	( ) light sens. eyes	( ) loss of smell	( ) cold sweats
( ) nervousness	( ) pins/needles-legs	( ) loss of memory	( ) loss of taste	( ) fever
( ) tension	( ) numbness-finger	( ) ears ring	( ) diarrhea	( ) ______________

( ) Symptoms other than above ____

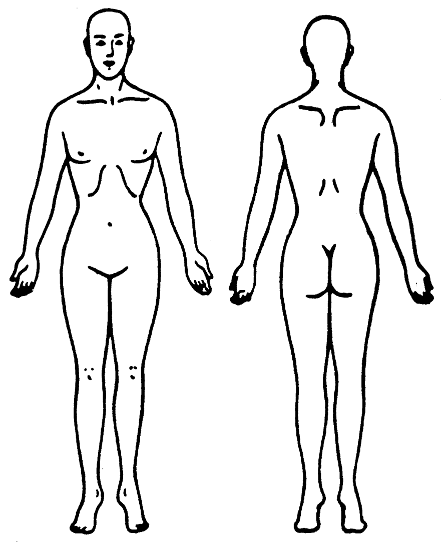
26. Have you lost time from work as a result of this accident? ( ) Yes ( ) No

a. Last day worked: ____
b. Type of employment: ____

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

28. Other pertinent information:
____
____
____

28. Please indicate on the diagrams where and what type of symptoms you are experiencing since the accident.



A=ACHE	B=BURNING	N=NUMBNESS
P=PINS & NEEDLES	S=STABBING	O=OTHER

Patient's Signature: ____ Date: ____/____/_____