INTO GREAT HEALTH
WITH CHARLIE SAVOCA, L.Ac.

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: ____/____/_____