Sunrise Chiropractic

"Optimizing the Experience of Life"

Personal Injury Questionnaire

NAME: _____Date of Accident_____

Where did accident happen? Describe the accident in your own words:

What was your position in the car?

☐ Driver: If Driver were your hands on the steering wheel? ☐ Left ☐ Right ☐ Both

☐ Passenger: If passenger, were you sitting in ☐ Front ☐ Right Rear ☐ Left Rear

Did your vehicle strike another vehicle ☐ yes ☐ No Speed of impact?_____

Was your vehicle struck by another vehicle ☐ Yes ☐ No Speed of impact?_____

Angles of impact… First Collision: ☐ Front ☐ Back ☐ Driver ☐ Passenger

Second Collision: ☐ Front ☐ Back ☐ Driver ☐ Passenger

Were you wearing a seat belt? ☐ Yes ☐ No

Did you brace for impact? ☐ Yes ☐ No ☐ I braced with my hands ☐ I braced with my feet

Which way were you facing at the time of impact? ☐ Straight ahead ☐ Left ☐ Right

Were the police notified? ☐ Yes ☐ No

Did the seat back bend / break? ☐ Yes ☐ No

Immediately following the accident, how did you feel? ☐ Dizzy/dazed ☐ disoriented

☐ Unconscious ☐ Nervous ☐ nauseous ☐ upset ☐ weak ☐ Other _____

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Did you strike anything in vehicle at time of impact? ☐ Yes ☐ No

If yes, specify what part of your body struck what:

☐Steering Wheel _____ ☐Dashboard _____

☐Windshield _____ ☐Roof_____

☐Left Side Door _____ ☐Right Side Door_____

☐Left Side Window _____ ☐Right Window _____

☐ Other _____

Did you go to hospital ☐ Yes ☐No Were you admitted to the hospital? ☐ Yes ☐ No

If yes how long? _____

If you went to hospital, when? ☐ At time of accident ☐ Next day

How did you get to hospital? ☐ Ambulance ☐ Police Car ☐ Private Transportation

Name of Hospital:_____

Attended by Dr. _____

What treatment was given?

☐None ☐Placed in a cervical collar ☐x-rayed ☐ given stitches ☐Bandaged

☐Given pain medication ☐given instructions regarding concussions

☐given instructions regarding sprains and strains ☐ Physical Therapy

☐Instructed to call an Orthopedic Surgeon ☐instructed to call a private physician

☐Referred to this office for treatment ☐ other _____

Have you seen any other doctor as a result of this accident? ☐ Yes ☐ No

Doctor's name _____

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Please describe how you felt:
A. During the accident:
B. Immediately after the accident:
C. Later that day:
D. The next day:

Please check any that apply

☐ **Neck pain:** select the areas that the pain runs into from the neck

☐None ☐Left shoulder ☐left arm ☐left forearm ☐left hand

☐Right shoulder ☐Right arm ☐right forearm ☐right hand

☐ **Upper Back Pain**

☐ **Low Back Pain:** select the areas of radiation, if any…

☐None ☐Left buttock ☐Left thigh ☐Left knee ☐Left foot

☐Right buttock ☐Right thigh ☐Right knee ☐Right foot

☐ **Numbness:**

☐ Left Hand ☐Left Upper Arm ☐Right Hand ☐Right Upper Arm

☐ Left Foot ☐Left Leg ☐Right Foot ☐Right Leg

Other Symptoms:

Headache ☐Constant ☐Occasional

Ringing in Ears ☐Yes ☐No ☐Left ☐Right ☐Both Ears

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Other Symptoms: (Cont.)

Blurry Vision	☐Yes	☐No	☐Left	☐Right	☐Both Eyes
Wrist Pain	☐Yes	☐No	☐Left	☐Right	☐Both Wrists
Jaw Pain	☐Yes	☐No	☐Left	☐Right	☐Both Sides
Hip Pain	☐Left	☐Right	☐Bilateral		
Foot Pain	☐Left	☐Right	☐Bilateral		

☐Dizziness ☐Nervousness ☐Fatigue ☐Anxiety ☐Depression ☐Excessive irritability

☐Fear of driving in a car ☐Loss of concentration ☐Jaw clenching ☐Grinding of teeth at night

☐Nightmares ☐Difficulty with sleeping

Additional Symptoms/ Complaints:_____

_____

_____

_____

_____

Have you lost any time from work due to your injuries? ☐Yes ☐No

If yes please give dates: _____

Type of employment: _____

Have you had previous injuries or accidents? ☐Yes ☐ No

Description of previous accident: _____

Description of previous injuries: _____

Is there any residual pain from the previous injury? ☐Yes ☐No

How much better did you feel prior to your current condition? (Example 100%, 80% etc.) _____

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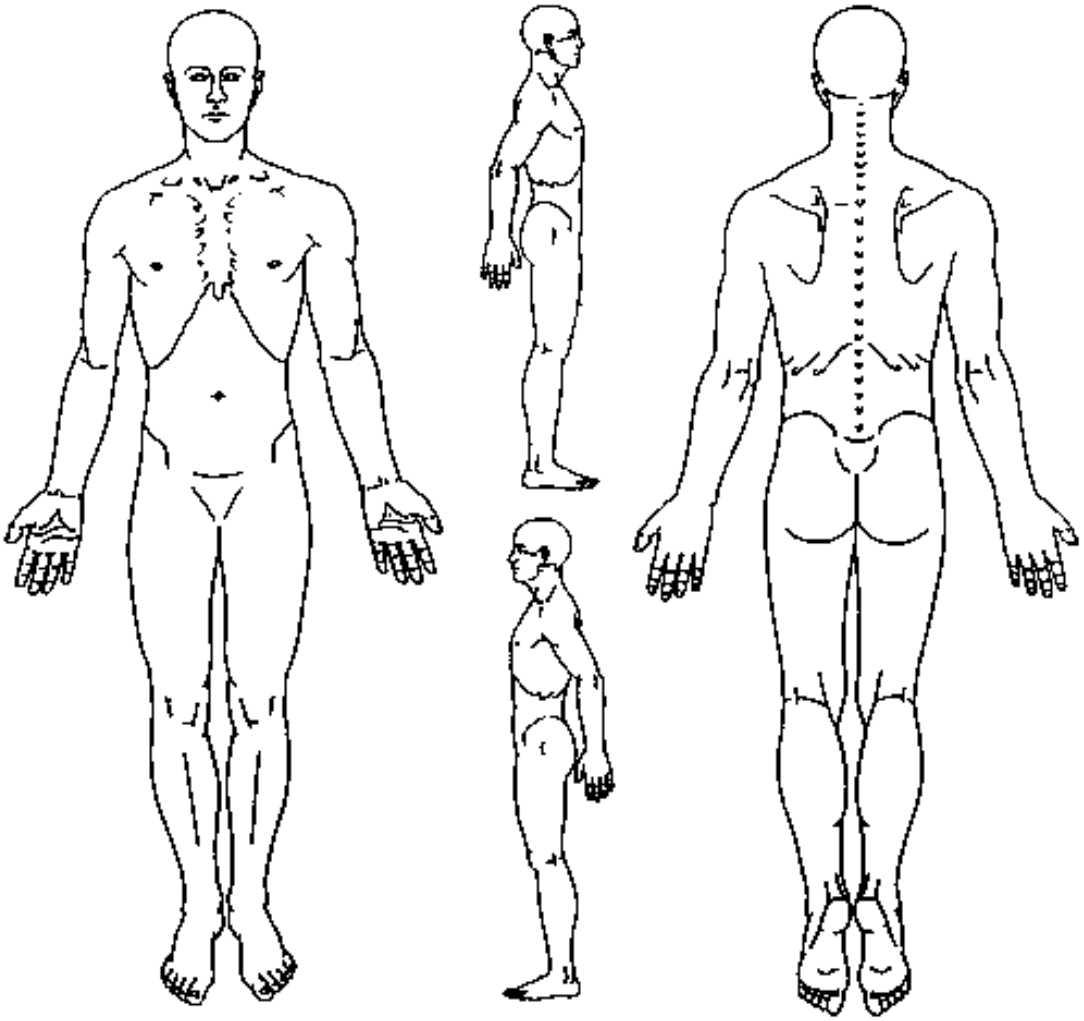

Please indicate the appropriate location of pain and the symbol that best describes the discomfort you are presently experiencing.

Sharp and Stabbing = + + + +

Dull and Achy = V V V V

Pins and Needles = 0 0 0 0

Numbness = / / / / / / /

Signature: _____ Date: _____

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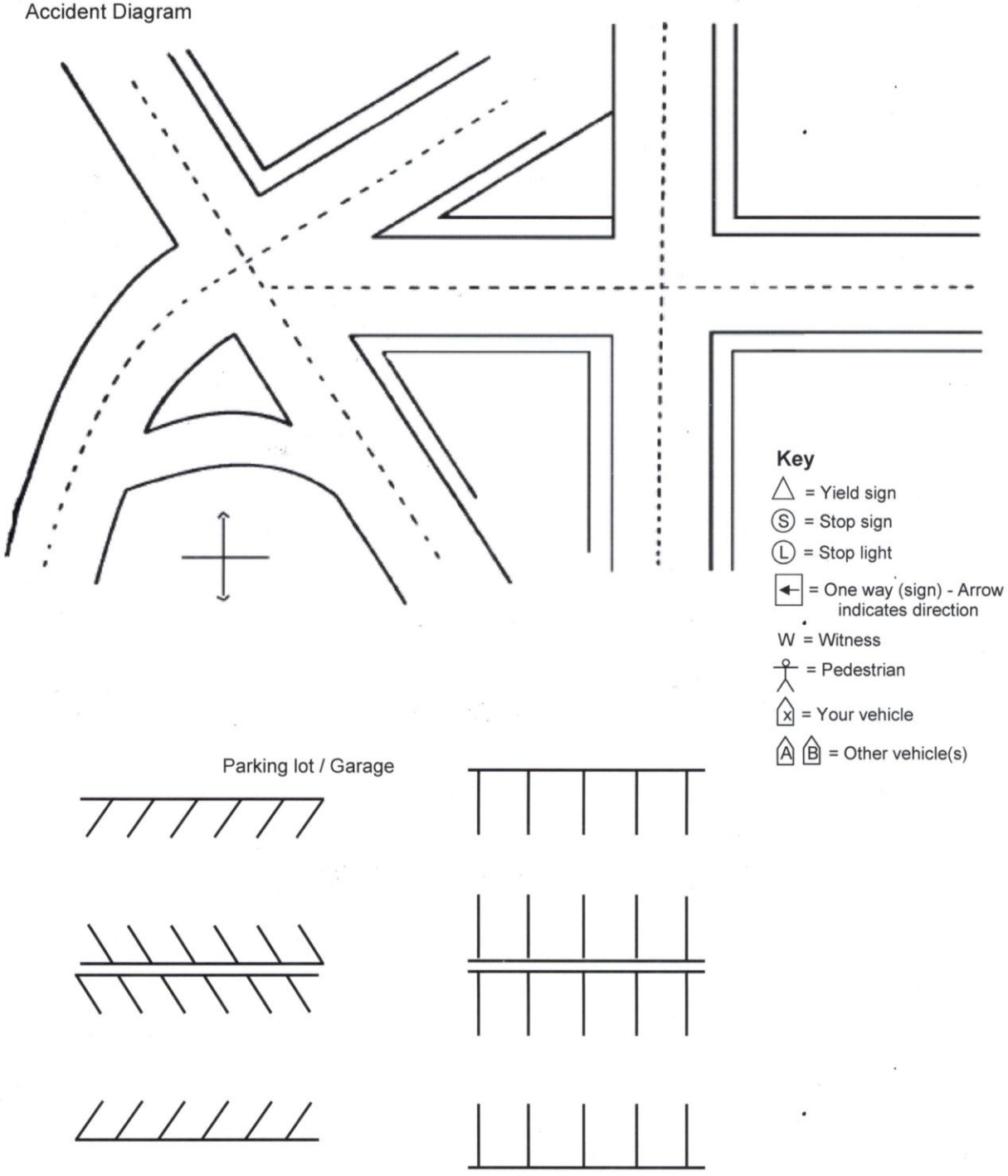
Accident Diagram



Show position of vehicle(s) and the direction of travel. Show all traffic signs and signals relevant to the accident. Note any obstructions and/or road surface type and condition. Feel free to add or create a new diagram as needed. Comments can be made to describe what happened or to clarify your diagram. If you add symbols to your diagram, enter the description in the symbol key.

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