PEARSON
Chiropractic & Rehabilitation Center

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PERSONAL INJURY QUESTIONNAIRE

Name _____ Date of Birth _____ Phone _____
Address _____ City _____ State _____ Zip _____
Employer's Name _____ Employer's Address _____
Your Ins. Co. _____ Policy # _____ Agent's Name _____
Driver/Other Vehicle _____ Ins Co. _____ Policy # _____
Have you retained an attorney? ( ) Yes ( ) No Name _____
Were there any witnesses? ( ) Yes ( ) No Name(s) _____

NATURE OF ACCIDENT:

1. Date of Accident _____ Time of Day _____
2. Were you: ( ) Driver ( ) Passenger ( ) Front Seat ( ) Back Seat
3. Number of people In your vehicle? _____ Other vehicle? _____
4. What direction were you headed? ( ) North ( ) East ( ) South ( ) West
   on (name of street) _____
5. What direction was other vehicle headed? ( ) North ( ) East ( ) South ( ) West
   on (name of street) _____
6. Were you struck from: ( ) Behind ( ) Front ( ) Left side ( ) Right side
7. Were you knocked unconscious? ( ) Yes ( ) No If yes, for how long? _____
8. Were police notified? ( ) Yes ( ) No
9. In your own words, please describe accident: _____

_____

_____

10. Did you have any physical complaints BEFORE THE ACCIDENT? ( ) Yes ( ) No
    If yes, please describe In detail: _____

_____

11. Please describe how you felt:
    a. DURING the accident: _____
    b. IMMEDIATELY AFTER the accident: _____
    c. LATER THAT DAY: _____
    d. THE NEXT DAY: _____
12. What are your PRESENT complaints and symptoms? _____
13. Do you have any congenital (from birth) factors which relate to this problem? ( ) Yes ( ) No
    If yes, please describe: _____
14. Do you have any previous illnesses which relate to this case? ( ) Yes ( ) No
    If yes, please describe: _____
15. 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.

_____

_____

16. Where were you taken after the accident?

17. 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?

18. Since this injury occurred are your symptoms ( ) Improving ( ) Getting Worse ( ) Same

19. CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT

❑ Headache	❑ Irritability	❑ 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	❑ Stomach Upset
❑ Sleeping Problems	❑ Head Seems Too Heavy	❑ Depression	❑ Fainting	❑ Constipation
❑ Back Pain	❑ Pins& Needles in Arms	❑ Lights Bother Eyes	❑ Loss of Smell	❑ Cold Sweats
❑ Nervousness	❑ Pins &Needles in Legs	❑ Loss of Memory	❑ Loss of Taste	❑ Fever
❑ Tension	❑ Numbness in Fingers	❑ Ears Ring	❑ Diarrhea	❑

Symptoms Other Than Above

20. Have you lost time from work as a result of this accident? ( ) Yes ( ) No. If yes, please complete this question.

a. Last Day Worked: _____

b. Type of Employment: _____

c. Are you being compensated for time lost from work? ( ) Yes ( ) No. If yes, please state type of compensation you are receiving: _____

21. Do you notice any activity restrictions as a result of this injury? ( ) Yes ( ) No. If yes, please describe, in detail: _____

_____

_____

_____

22 Other pertinent Information: _____

_____

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_____

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_____

Signature _____ Date _____