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GERCKENS CHIROPRACTIC

PERSONAL INJURY QUESTIONNAIRE

Work Phone ( ) _____

Name _____ Home Phone ( ) _____

Address _____ City _____ State _____ Zip _____

Age _____ Birth date _____ Sex _____ S/S # _____

Employer's Name _____ Employer's Address _____

Your Ins. Co. _____ Policy # _____ Agent's Name _____

Responsible Party's Name _____

Address _____ City _____ State _____ Zip _____

Policy Holder's Name _____ Policy # _____

ATTORNEY

Name _____ Phone ( ) _____

Address _____ City _____ State _____ Zip _____

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? _____ Were you wearing seat belts? _____
4) What direction were you headed? ☐ North ☐ East ☐ South ☐ West
   On (name of street) _____
5) What direction was the 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) Where were you taken after this accident? _____

16) Have you been treated by another doctor since this accident? ☐ Yes ☐ No If yes, please list doctor's name and address:

_____

What type of treatment did you receive? _____

_____

17) Since this injury occurred, are your symptoms: ☐ Improving ☐ Getting Worse ☐ Same

18) 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 _____

19) 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) Present Salary: _____

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

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

_____

_____

_____

21) 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: _____

_____

_____

22) Other pertinant information: _____

_____

_____

_____

_____ _____

DATE PATIENT'S SIGNATURE