ASH
Chiropractic & Wellness

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 hand 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

Angles of impact…..First Collision: □ Front □ Back □ Left □ Right

If Second Collision: □ Front □ Back □ Left □ Right

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 the impact … □ straight ahead □ Left □ Right

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

If yes, specify what part of you body struck what: ie… head, chest, shoulder right/left Knee

□ Steering Wheel _____ □ Dashboard _____

□ Windshield _____ □ Roof _____

□ Left Side Door _____ □ Right Side Door _____

□ Left Side Window _____ □ Right Window _____

□ Other_____

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 _____

Did you go to the 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 □ place 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 Orthopedic Surgeon □ instructed to call private physian

□ referred to this office for treatment □ Other _____

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

Doctor's name

CHIEF Complaints or Symptoms:

□Neck Pain □ none □ left shoulder □ left arm □ left forearm □ left hand
Check off the areas that pain runs into from the neck □ right shoulder □ right arm □ right forearm □ right hand

□ headache
□ Migraine Headache
□ upper back pain

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

Blurry Vision □ Yes □ No □ Left □ Right □ Both Eyes

Wrist Pain □ Yes □ No □ Left □ Right □ Both Wrists

Jaw Pain □ Yes □ No □ Left □ Right □ Both Sides

□ 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 at night

□ **Low Back Pain** □ none □buttocks □ left buttock □ left thigh □ left knee
Select the areas of radiation, is any… □ left foot □ right buttock □ right thigh □ right knee □ right foot

Hip Pain	□ Left	□ Right	□ Bilateral
Knee Pain	□ Left	□ Right	□ Bilateral
Foot Pain	□ Left	□ Right	□ Bilateral

Numbness:

□ Left Hand	□ Left Upper Arm	□ Right Hand	□Right Upper Arm
□ Left Foot	□ Left Leg	□ Right Foot	□ Right Leg

Additional Symptoms/Complaints:

_____
_____
_____
_____
_____
_____

Have You lost any time from work due to your injuries? □ Yes □ No
If yes please give dates: _____
Type of employment: _____