

# Harcourt Chiropractic Office, LLC

## Personal Injury Questionnaire

Patients Name: \_\_\_\_\_ Today's date \_\_\_\_/\_\_\_\_/\_\_\_\_  
Your Insurance Company \_\_\_\_\_ Policy # \_\_\_\_\_  
Driver of other Vehicle \_\_\_\_\_ Policy # \_\_\_\_\_ Ins. Co \_\_\_\_\_  
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  
Your Vehicle Year? \_\_\_\_\_ Make? \_\_\_\_\_ Model? \_\_\_\_\_  
Other Vehicle Year? \_\_\_\_\_ Make? \_\_\_\_\_ Model? \_\_\_\_\_
3. Number of people in your vehicle? \_\_\_\_\_ Other Vehicle? \_\_\_\_\_
4. What direction were you headed? ( ) North ( ) South ( ) East ( ) West  
On (name of street) \_\_\_\_\_ going approx. \_\_\_\_\_ speed (MPH)
5. What direction was the other vehicle headed? ( ) North ( ) South ( ) East ( ) West  
On (name of street) \_\_\_\_\_ going approx. \_\_\_\_\_ speed (MPH)
6. Were you struck from? ( ) Behind ( ) Front ( ) Left Side ( ) Right Side
7. In your words, please describe the accident: “ \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
8. What were the road conditions: ( ) Dry ( ) Wet ( ) Snow covered ( ) Icy ( ) Other
9. Were you aware of the impending accident? ( ) Yes ( ) No
10. What direction were you looking at the time of the accident? ( ) Right ( ) Left ( ) Straight Ahead
11. Were you wearing a seat belt? ( ) Yes ( ) No Shoulder belt? ( ) Yes ( ) No
12. Did you hit your head or have any facial injuries? ( ) Yes ( ) No Explain: \_\_\_\_\_  
a. Were you knocked unconscious? ( ) Yes ( ) No If so, for how long? \_\_\_\_\_  
b. Were your glasses knocked off or dentures knocked out? ( ) Yes ( ) No
13. Were the police notified? ( ) Yes ( ) No  
a. Were any of the other occupants in your vehicle? ( ) Yes ( ) No Explain: \_\_\_\_\_  
\_\_\_\_\_  
b. Was your vehicle towed away? ( ) Yes ( ) No Explain: \_\_\_\_\_  
c. What is the estimated damage to your vehicle \$ \_\_\_\_\_ Other vehicle? \$ \_\_\_\_\_
14. Please describe how you felt:  
a. DURING the accident: \_\_\_\_\_  
b. IMMEDIATELY AFTER the accident: \_\_\_\_\_  
c. LATER THAT DAY: \_\_\_\_\_  
d. THE NEXT DAY: \_\_\_\_\_

15. Where were you taken after the accident? \_\_\_\_\_
- a. Did you go to the hospital? ( ) Yes ( ) No If yes, which hospital? \_\_\_\_\_
- b. Were x-rays taken? ( ) Yes ( ) No If yes, where were they taken? \_\_\_\_\_
- c. Were there any treatments rendered? ( ) Yes ( ) No Explain: \_\_\_\_\_
- d. Are you taking any medication/analgesic/muscle relaxant? ( ) Yes ( ) No

16. Have you been treated by another doctor since the accident? ( ) Yes ( ) No

Name and address: \_\_\_\_\_

17. Since this injury occurred, are your symptoms: ( ) Improving ( ) Same ( ) Getting worse

18. Did you have physical complaints BEFORE THE ACCIDENT? ( ) Yes ( ) No

If yes, please describe in detail \_\_\_\_\_

19. CHECK SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT WHICH APPEAR TO BE A DIRECT RESULT OF THIS ACCIDENT:

- |                       |                            |                                  |                     |                   |
|-----------------------|----------------------------|----------------------------------|---------------------|-------------------|
| ( ) Headache          | ( ) Irritability           | ( ) Numbness in Toes             | ( ) Face Flushed    | ( ) Feet Cold     |
| ( ) Neck Pain         | ( ) Chest Pain             | ( ) Shortness of Breath          | ( ) Buzzing in Ears | ( ) Hands Cold    |
| ( ) Neck Stiffness    | ( ) 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        |                   |
| ( ) Seizures          | ( ) Loss of consciousness  | ( ) Visual Disturbances Symptoms |                     |                   |

Other Than Above \_\_\_\_\_

20. What are your PRESENT complaints and symptoms? \_\_\_\_\_

21. Do you have any congenial (from birth) factors which relate to this problem? ( ) Yes ( ) No

If yes, please describe \_\_\_\_\_

22. Do you have any previous illnesses which relate to this case? ( ) Yes ( ) No

If yes, please describe \_\_\_\_\_

23. Have you ever been involved in an accident before? ( ) Yes ( ) No

If yes, please describe, including date(s) and types(s) of accident, as well as injury(ies) received: \_\_\_\_\_

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

a. Last day worked \_\_\_/\_\_\_/\_\_\_

b. What is your occupation? \_\_\_\_\_

- c. Are you being compensated for time lost from work? ( ) Yes ( ) No

If yes, please state type of compensation you are receiving: \_\_\_\_\_

25. Do you notice any activity restrictions as a result of this injury? ( ) Yes ( ) No

If yes, please describe in detail \_\_\_\_\_

26. Other pertinent information: \_\_\_\_\_

\_\_\_\_\_

Date

\_\_\_\_\_

Signature