Harcourt Chiropractic Office, LLC
Personal Injury Questionnaire

Patients Name: ______________________ Today's date ____/____/____

Your Insurance Company ______________ Phone # ______________ Policy # ______________

Did you report your injury to your insurance company? ( ) Yes ( ) No Medical Claim #______________

Adjuster Name: ______________ Phone #: ______________ ext______

Medical Mailing Address: ______________ City ______ State ______ Zip: ______

Your first party medical benefits? $__________ Your tort option on your policy? ( ) Limited Tort ( ) Full Tort

Driver of other Vehicle ______________ Policy # ______________ Ins. Co ______________

Have you retained an attorney? ( ) Yes ( ) No Name of Law Firm ______________

Attorney Name ______________

Attorney Address ______________ State ______ City ______ Zip ______

Attorney Phone #: ( ) ______________ Attorney Fax # ( ) ______________ Attorney Email ______________

Were there any witnesses? ( ) Yes ( ) No Name(s) ______________

NATURE OF ACCIDENT

1. Date of Accident ______________ Time of Day ______________ City/State of Accident ______________
2. Were you: ( ) Driver ( ) Passenger ( ) Front Seat ( ) Back Seat

   Your Vehicle Year? ______ Make? ______ Model? ______ Type? ______

   Other Vehicle Year? ______ Make? ______ Model? ______ Type? ______
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 APPEARS 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 congenital (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 ____________________

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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 " ____________________

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26. Other pertinent information: ____________________

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____________________ ____________________

Date Signature