

PERSONAL INJURY QUESTIONNAIRE

Name _____ Phone (____) _____

Address _____ City _____ State _____ Zip _____

Age _____ Birth date _____ Sex: Female Male SS# _____

Employer's Name _____ Employer's phone number (____) _____

Employer's Address _____

NATURE OF ACCIDENT:

1. Date of Accident _____ Type of Accident (Auto, Slip, Fall, etc.) _____

2. If auto, were you: Driver Passenger Front Seat Back Seat

3. Were you struck from: Behind Front Left Side Right Side

4. Approximate speed of your car _____ mph

5. Were you knocked unconscious? Yes No If yes, for how long? _____

6. Were police notified? Yes No

7. In your own words, please describe accident in detail: (Draw picture if necessary) _____

8. Did you have any physical complaints BEFORE THE ACCIDENT? Yes No If not due to Auto please explain: _____

9. Please describe how you felt:

a. DURING the accident: _____

b. IMMEDIATELY AFTER the accident: _____

c. LATER THAT DAY: _____

d. THE NEXT DAY: _____

10. What are your PRESENT complaints and symptoms? _____

11. Do you have any congenital (from birth) factors which relate to this problem? Yes No If yes, please describe: _____

12. Do you have any previous illnesses which relate to this case? Yes No If yes, please describe: _____

13. 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 injur(ies) received: _____

14. Were you hospitalized after the accident? _____

15. Have you been treated by another doctor since the accident? Yes No If yes, please list the doctor's name and address:

What type of treatment did you receive? _____

16. Since this injury occurred, are your symptoms: Improving Getting Worse Same

17. CHECK THE SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT:

- | | | | | |
|--|---|--|--|--|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Irritability | <input type="checkbox"/> Numbness in Toes | <input type="checkbox"/> Face Flushed | <input type="checkbox"/> Feet Cold |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Buzzing in Ears | <input type="checkbox"/> Hands Cold |
| <input type="checkbox"/> Neck Stiff | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Stomach Upset |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Head Seems Too Heavy | <input type="checkbox"/> Depression | <input type="checkbox"/> Fainting | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Pins & Needles in Arms | <input type="checkbox"/> Lights Bother Eyes | <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> Cold Sweats |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Pins & Needles in Legs | <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Loss of Taste | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Tension | <input type="checkbox"/> Numbness in Fingers | <input type="checkbox"/> Ears Ring | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> _____ |

Symptoms Other Than Above: _____

18. Have you lost time from work as a result of this accident? Yes No

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

ATTORNEY:

Name _____ Phone (_____) _____

Address _____ City _____ Zip _____

Patient's Auto Insurance

Name of Company _____

Policy # _____

Claim # _____

Billing Address _____

Agent Name _____

Agent Phone Number (_____) _____

Patient's Health Insurance

Name of Company _____

Subscriber # _____

Date of Birth _____

Relationship to Patient _____

Policy # _____

Group # _____

Assignment and Release

I, the undersigned certify that I (or my dependent) have insurance coverage with the above stated insurance companies and assign directly to Shepherd Chiropractic all insurance benefits. I understand that **I am financially responsible for all charges whether or not paid by insurance.** I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature _____

Relationship _____ Date _____

