

PLANET CHIROPRACTIC
Automobile/PI Accident or Work Comp Questionnaire

Patient's Name

Date of the accident

DOB

Please explain in detail how your accident happened.

What were the time and date of present injury?

Where did you feel pain immediately after the accident?

List the extent of your injuries as you know them:

Did you require post accident hospitalization? Yes/ No

Check symptoms you have noticed since the accident:

- | | | | |
|-------------------------------|--------------------------|-------------------|--------------------------|
| ____ Headache | ____ Dizziness | ____ Depression | ____ Fatigue |
| ____ Light Bothers Eyes | ____ Buzzing in Ears | ____ Diarrhea | ____ Neck Pain |
| ____ Head Seems too Heavy | ____ Memory Loss | ____ Feet Cold | ____ Neck Stiff |
| ____ Pins and Needles in Arms | ____ Ears Ring | ____ Hands Cold | ____ Fainting |
| ____ Sleeping Problems | ____ Back Pain | ____ Face Flushed | ____ Loss of Balance |
| ____ Pins and Needles in Legs | ____ Constipation | ____ Tension | ____ Nervousness |
| ____ Loss of Smell | ____ Fever | ____ Irritability | ____ Numbness in Toes |
| ____ Loss of Taste | ____ Chest Pain | ____ Cold Sweats | ____ Shortness of Breath |
| ____ Stomach Upset | ____ Numbness in fingers | | |

Symptoms other than above: _____

Where were you taken after the accident? _____

Hospitalized? Yes/ No If yes, admitted? _____ How long? _____

Name of Hospital _____

Name of Doctors _____

What treatment was given? _____

Were x-rays taken at the hospital ? Yes/No

Was any other doctor consulted after your accident? Yes/ No

If so, what was the doctor's name? _____ D.C., M.D., D.O., D.D.S.

What was the diagnosis? _____

What treatment was given? _____

How often did you see the doctor? _____

How long did you see the doctor? _____

Have you ever had any complaints in the involved area before? Yes/ No

If so, what were the complaints? _____

Before the injury were you capable of working on an equal basis with others your age? Yes/ No

Are your work activities restricted as a result of this accident? Yes/ No

Since this injury are your symptoms, Improving? Getting worse? Same?

Driver of other vehicle (if any)

Name _____ Insurance Company _____ Policy No. _____

Driver of vehicle in which you were injured (if applicable)

Name _____ Insurance Company _____ Policy No. _____

Name of your insurance adjustor _____

Have you retained an attorney? Yes/ No

If so, his/her name and contact number _____

You were heading North/ East/ South/ West on _____ (street or highway)

Other vehicle was heading North/ East/ South/ West on _____ (street or highway)

Were police notified? Yes/ No

Were you knocked unconscious? Yes/ No If so, for how long? _____

You were struck from Behind/ Front/ Left Side/ Right Side _____

You were Driver/ Passenger/ Front seat/ Back Seat/ Using seat belts _____

Patient's Name

DOB

Patient's Signature

Date