Paloma Chiropractic & Massage Therapy

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Personal Injury Questionnaire

Patient Name: ______________________________ **DOB**_______________ **Height**_________
Weight __________
Your Auto Insurance Co.______________________ **Insurance Claims Phone:**
____
Adjuster's Name: _____________________________ **Adjuster's Phone:**
____
Accident Claim Number: _____________________________________ **Date of Accident:**
____________________ **Time of day:** ______________ **State in which accident occurred:**
____

Circle answers where appropriate:
Was the accident on the job? Yes No
Number of people in your vehicle? ___________ Other vehicle: ________________________
Your position in vehicle: ____________________ Name of person driving:
____
Were police notified? Yes No Was a police report made? Yes No
Road Conditions: Dry Wet Snowy Icy **Visibility:** Dawn Daylight Dusk Dark
Direction you were headed: North South East West on (name of street)
____
Other Vehicle was headed: North South East West on (name of street)
____

Vehicle Description:
Your Vehicle: Make/Model____________________________
At time of impact was your vehicle: Stopped Slowing Accelerating Estimated Speed:
____
If stopped, was your foot on the brake? Yes No Was your vehicle totaled?
____
Were any auto parts broken during the accident?
____
Other Vehicle: Make/Model ________________________________
At time of impact was **their** vehicle: Stopped Slowing Accelerating Estimated Speed:
____
Was the other vehicle totaled? _______________

During the accident:
In your own words, describe the accident:
____
____
Were you struck from: Behind Front Left Right Other:
____
Did your vehicle strike any other objects during the accident? Yes No If Yes, what?
____

Were you knocked unconscious? Yes No If yes, for how long? ________________
Were you aware of the impending collision? Yes No

Were you wearing a restraint? Yes No **If yes**: Lap Belt only Shoulder/Lap Belt Other:________
Were you bruised from the restraint? Yes No Did your airbag deploy? Yes No
Which way was your **body** facing at the time of impact? Straight Right Left Other: _____________
Which way was your **head** facing at the time of impact? Straight Right Left Other: _____________
On what part of the vehicle did the following body parts hit, if any?
Head ____________ Chest ___________ Right/Left Shoulder ___________ Right/Left arm __________
Right/Left Hip __________ Right/ Left Leg ____________ Right/Left Knee ____________ Other________
How far was your head from the head rest? ___________ (inches)

After the accident:
Where did you go after the accident? Emergency Room Home Work Other: ___________________
How did you get there? Ambulance Your Car Friend's Car Other: _____________________________
Have you received treatment since the accident? Yes No If yes, where? __________________________
What type of treatment did you receive? ____

Describe your physical and mental feelings **during** the accident, **immediately after** the accident, **later that day,** and **the next day:**
During: ____
Immediately after: ____
Later that day: ____
The next day: ____
Have you noticed any activity restrictions as a result of this injury? Yes No
If yes, describe: ____
Were you having any physical complaints before the accident? Yes No
If so, Describe: ____
Have you lost work time as a result of this accident? Yes No If yes, how much: ___________________
Are you being paid for time lost from work? Yes No

Have you ever been involved in an accident before? Yes No
If so, please describe including dates and types of accidents: ____
____

Check all of the following symptoms you have noticed since the accident:
__Headache __Restlessness __Loss of smell __Upset Stomach
__Neck Pain __Nervousness __Loss of taste
__Diarrhea
__Forgetfulness __Sleeping problems __Light sensitivity
__Constipation
__Difficulty concentrating __Heavy Head __Face Flushed
__Fever
__Loss of Memory __Tension __Chest Pain
__Other:________
__Disoriented __Dizziness __Short of Breath
____
__Nauseated __Fainting __Cold Sweats
____
__Blurred Vision __Irritability __Stiff Neck
____
__Confused __Depression __Back Pain
__Light Headedness __Loss of Balance __Cold hands/feet
__Ringing in ears __Fatigue __Numbness in toes and fingers
__Pins and needles in arms or legs __Reduced tolerance to __Heat __Alcohol

Do you have any congenital (from birth) factors which relate to these problems? Yes No
If yes, please explain:
____
____

Signature: ______________________________ Date: _________________