Walter Chiropractic Clinic
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PERSONAL INJURY QUESTIONAIRE

Patient Name: _____ Today's Date: _____

Full Address: _____

DOB: _____ Phone # _____Secondary # _____

Employer: _____ Employer's Phone # _____

Your Insurance Company: _____ Policy # _____

Adjustor's Name: _____ Adjustor's Phone #_____

Claim # _____ Email:_____

Name of Driver/Other Vehicle: _____

Insurance Co. _____ Policy # _____

Date of Accident: _____ Time of Day: _____

Your position in vehicle: ☐ Driver ☐ Passenger Seat ☐ Back Seat

The impact on *your* vehicle: ☐ Left ☐ Right ☐ Front ☐ Rear ☐ Side ☐ Head-on

The movement of the vehicle *you* were in: ☐ Stopped ☐ Backing Up ☐ Forward
☐ Turning Left ☐ Turning Right

Check the statement that best describes the speed of your vehicle:

☐ Less than 15MPH ☐ Up to 25MPH ☐ Up to 40MPH
☐ Up to 65MPH ☐ Greater than 65MPH ☐ Unknown

Check the box that best describes the damage to your vehicle:

☐ No visible damage ☐ Slight visible damage ☐ Totaled
☐ Moderate visual damage ☐ Heavy visible damage

The impact to the *other* vehicle: ☐ Left ☐ Right ☐ Front ☐ Rear ☐ Side ☐ Head-on

Circle the movement of the *other* vehicle: ☐ Stopped ☐ Backing Up ☐ Forward
☐ Turning Left ☐ Turning Right

Was *your* vehicle towed from the scene? ☐ Yes ☐ No

Accident Location: _____

_____

Number of people in *your* vehicle: _____

Do you have a police report? ☐ Yes ☐ No

Were police notified? ☐ Yes ☐ No

Did airbags deploy? ☐ Yes ☐ No

Were you wearing your seat belt? ☐ Yes ☐ No Which airbags: _____

Did any part of your body hit the vehicle? _____

_____

_____

Did an ambulance arrive at the scene? ☐ Yes ☐ No Did they examine you? ☐ Yes ☐ No

Where did you go after the accident? ☐ Home ☐ Hospital ☐ Urgent Care
☐ Other: _____

Have you been treated by another doctor since the accident? ☐ Yes ☐ No

If yes, please list the doctor(s) and their phone number: _____

What type of treatment did or are you receiving? _____

_____

Please describe the location of your symptoms at the time of the accident: _____

_____

_____

Since this injury occurred are your symptoms: ☐ Improving ☐ Getting worse ☐ Same

Please check all that apply:

- ☐ Dull pain
- ☐ Sharp pain
- ☐ Aching
- ☐ Burning
- ☐ Shooting
- ☐ Tight/Stiff
- ☐ Tingling
- ☐ Numbness:
  - ☐ Fingers
  - ☐ Toes
  - ☐ Arms
  - ☐ Legs
  - ☐ Other
- ☐ Nausea
- ☐ Palpitations
- ☐ Chest Pain
- ☐ Depression
- ☐ Anxiety/Panic
- ☐ Weakness
- ☐ Fatigue
- ☐ Shortness of Breath
- ☐ Disbelief
- ☐ Dizziness
- ☐ Facial Pain
- ☐ Headaches
- ☐ Irritability
- ☐ Muscle Spasm
- ☐ Rib Pain
- ☐ Neck Pain
- ☐ Back Pain
- ☐ Sleeping Differences
- ☐ Shock
- ☐ Soreness
- ☐ Stomach Pain
- ☐ Stress
- ☐ Upset
- ☐ Tension
- ☐ Loss of Memory
- ☐ Ringing in Ears
- ☐ Pins & Needles:
  - ☐ Fingers
  - ☐ Toes
  - ☐ Arms
  - ☐ Legs
  - ☐ Other

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

Last day worked: _____ Type of employment: _____

Present salary: _____

Are you being compensated for time lost from work? ☐ Yes ☐ No

Type of compensation: _____

Do you notice any activity restrictions as a result of this injury? ☐ Yes ☐ No

If yes, please describe in detail _____

_____

Any other pertinent information? _____

_____

_____

Patient/Guardian Name (Print): _____Date:_____

Patient/Guardian Signature: _____