

Spinal Center Clinics

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PERSONAL INJURY QUESTIONNAIRE

Date of appointment: _____

Name: _____ Birth date: _____
Last First Middle

Address: _____ Age: _____ Sex: F _____ M _____
Street

City _____ State _____ Zip _____ Race: _____

Home Phone #: _____ Cell Phone #: _____

Social Security Number: _____

EMPLOYMENT DATA:

Employer: _____ Address: _____

Work Phone: _____ City _____ State _____ Zip _____

Occupation: _____ Work activities: _____

MARITAL STATUS: (Please circle one)

Single Married Divorced Separated Widowed

TYPE OF INSURANCE: Health Ins. Automobile Ins. Workman's Comp.

Name of Insurance Company and Address: _____

Policy or Claim Number: _____

Have you retained an attorney for this accident? YES, NO, or NOT YET?

If yes, name of attorney? _____

IF THE INSURANCE INFORMATION YOU GAVE US IS NOT IN YOUR NAME, WE NEED THE FOLLOWING:

Whose name is the insurance under? _____

Their address: _____

Their date of birth: _____ Sex M _____ F _____

What is your relationship to this person? _____

NATURE OF ACCIDENT (Circle or write in answers)

Date of Accident: _____ Time of Day: _____ A.M. P.M.

Were you the DRIVER or PASSENGER? Were you sitting in the FRONT or BACK?

Whose car were you in? _____

What was the year and type of the vehicle you were in? _____

Were you struck from BEHIND, FRONT, LEFT SIDE, or RIGHT SIDE?

Were you wearing your seat belt or shoulder restraint? YES or NO?

Did you strike any object in the car with your head or body? YES or NO? If yes, please explain: _____

Were you knocked unconscious? YES or NO?

Were the police notified? YES or NO? If yes, was a ticket issued? YES or NO?

If yes, who was it issued to? YOU or THE OTHER VEHICLE'S DRIVER?

What was the approximate amount of damage done to the vehicle you were in? _____

In your own words, describe the accident and how it happened? _____

COMPLAINT OF INJURY

Please list your areas of pain. Where are you hurting now?

AREA

AREA

1) _____

3) _____

2) _____

4) _____

Were you taken to the hospital immediately after the accident? YES or NO?

If yes, how did you get there? AMBULANCE, DROVE YOURSELF, FRIEND, or OTHER _____?

If no, were you taken LATER THAT DAY, NEXT DAY, or OTHER _____?

Name of hospital? _____

Treatment given: _____

Were x-rays taken? YES or NO? If yes, what areas? _____

Were you INPATIENT or OUTPATIENT?

Names of medications or prescription dispensed? _____

Emergency doctor's results/conclusions/diagnosis: _____

Have you been treated by any other doctors as a result of the injuries sustained in your automobile accident? Please list them in order.

| DOCTOR | DATES | TYPE OF TREATMENT |
|----------|-------|-------------------|
| 1) _____ | _____ | _____ |
| 2) _____ | _____ | _____ |
| 3) _____ | _____ | _____ |

List any specialized tests that were performed and their results, if known.

| TEST | RESULTS |
|----------|---------|
| 1) _____ | _____ |
| 2) _____ | _____ |

Since the accident, is your condition getting WORSE, THE SAME, or BETTER?

Is your pain worse at times (i.e mornings, afternoons, nights)? _____

What aggravates the pain (i.e. sitting, standing, walking, etc.)? _____

What relieves your pain (i.e. ice pack, heating pad, meds)? _____

CHECK THE SYMPTOMS YOU HAVE EXPERIENCED SINCE THE ACCIDENT OCCURRED.

- () Headaches () Dizziness () Depression () Neck pain () Head too heavy
() Tension () Irritability () Fatigue () Neck stiffness () Light bothers eyes
() Cold sweats () Fever () Nervousness () Back pain () Sleeping problems
() Chest pain () Ears ringing () Face flushed () Diarrhea () Loss of memory
() Shortness of breath () Loss of balance () Fainting spells () Numbness in fingers
() Numbness in toes () Pins & needles in arms () Pins & needles in legs

EMPLOYMENT PROFILE

Were you employed at the time of the accident? YES or NO?

Did you lose time from work as a result of this injury? YES or NO?

Last day worked? _____ Number of days lost: _____

Are you being compensated for the lost time? YES or NO? If yes, please state the type of compensation you are receiving. _____

SOCIAL PROFILE

Do you smoke? YES or NO? Number of cigarettes a day? _____

Do you drink? YES or NO? How much? _____

What are your recreational activities? _____

Describe any restrictions as a result of the injury (at home, work, hobbies, etc.) _____

Are you right-handed or left-handed? Please circle.

PAST MEDICAL HISTORY

Have you had any other automobile, on the job, or other accidents/injuries? If so, please list below in order.

| | TYPE OF INJURY | DATE OF INJURY | AREA HURT IN INJURY |
|----|----------------|----------------|---------------------|
| 1) | _____ | _____ | _____ |
| 2) | _____ | _____ | _____ |
| 3) | _____ | _____ | _____ |

Previous treatment? YES or NO?

Previous litigation? YES or NO? Settled? YES or NO?

Impairment residuals or disability? YES or NO? Percentage rating: _____

Previous operations and approximate dates:

| | | |
|----|-------|-------|
| 1) | _____ | _____ |
| 2) | _____ | _____ |
| 3) | _____ | _____ |
| 4) | _____ | _____ |

Family Physician: _____ Date of Last Visit: _____

At present, are you being treated by any other physician for any condition? YES or NO? If yes, name:

Present medications: _____

Medical allergies: _____

FEES ARE PAYABLE AT THE TIME X-RAYS, EXAMINATIONS, AND TREATMENT ARE RECEIVED UNLESS PRIOR ARRANGEMENTS ARE MADE. X-RAYS REMAIN THE PROPERTY OF THIS CLINIC.

Patient consent for treatment: _____
SIGNATURE

Date: _____

Guardian consent for treatment: _____
(If under 18 years of age) SIGNATURE

Nearest Relative Not Living With You: _____

Phone #: _____ Address: _____

Relationship: _____