CARDINAL CHIROPRACTIC CENTERS®

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PERSONAL INJURY QUESTIONNAIRE

PATIENT INFORMATION											
Patient's last name:		First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one)					
						Single / Mar / Div / Sep / Wid					
Is this your legal name?		Other legal or former name:		Social Security no.:		Birth date:		Age:	Sex:		
❑ Yes	❑ No					/ /			❑ M	❑ F	
Street address:			Apt. #:	E-mail address:		Home phone no.:					
						( )					
City:		State:		Zip Code:		Cell phone no.:					
						( )					
Occupation:			Employer:			Employer phone no.:					
						( )					
Auto Insurance Company:			Name on Policy (if different):			Policy #:					
Responsible Party's Name:			Policy Holder's name:			Policy#:					
Address:			City:			State:		Zip:			

NATURE OF ACCIDENT											
Date of accident:				Time of accident:							
Please describe the accident in your own words:											
Were you:	☐ Driver	☐ Passenger: ☐ Front Seat ☐ Back Seat		Number of people in your vehicle (including you):							
Were you wearing seat belts?		☐ Yes	☐ No	Did the airbag deploy?		☐ Yes	☐ No				
What direction were you headed?		☐ North	☐ South	☐ East	☐ West						
Name of street you were traveling on:											
What direction was the other vehicle headed?		☐ North	☐ South	☐ East	☐ West						
Name of street other vehicle was traveling on:											
Where you struck from:		☐ Front	☐ Rear	☐ Driver Side	☐ Passenger Side						
Was your foot on the brake?		☐ Yes	☐ No	Were the police notified?		☐ Yes	☐ No				

YOUR INJURIES				
Were you:	☐ Cut	☐ Bruised	☐ Bleeding	☐ Knocked unconscious
Where was the injury?				For how long?
Did you strike any objects inside the car?				
☐ Steering Column	☐ Dashboard	☐ Windshield	☐ Rearview Mirror	☐ Headrest
☐ Seat Broke	☐ Door Panel	☐ Side Window	☐ Cannot Remember	☐ Other
If other, please describe:				
What portion of your body did you hit?				
☐ Head	☐ Face	☐ Chest	☐ Arms	☐ Knees	☐ Other
If other, please describe:				
Please describe how you felt at the following times (were you having any pains?):				
During the accident:				
Immediately after the accident:				
Later that day:				
The next day:				
Did you have any physical complaints before the accident? ☐ Yes ☐ No If yes, please describe below.				
Do you have any congenital (from birth) factors which relate to this problem? ☐ Yes ☐ No If yes, please describe below.				
Do you have any previous illnesses which relate to this case? ☐ Yes ☐ No If yes, please describe below.				
Check any symptoms you have had since the accident?				
☐ Headache	☐ Neck Pain	☐ Neck Stiffness	☐ Fever	☐ Face Flushed
☐ Head Overly Heavy	☐ Dizziness	☐ Loss of Balance	☐ Fainting	☐ Loss of Memory
☐ Ringing in Ears	☐ Buzzing in Ears	☐ Lights Bother Eyes	☐ Loss of Smell	☐ Loss of Taste
☐ Nervousness	☐ Tension	☐ Irritability	☐ Fatigue	☐ Depression
☐ Mid Back Pain	☐ Chest Pain	☐ Shortness of Breath	☐ Shoulder Pain	☐ Pins & Needles in Arms
☐ Numbness in Fingers	☐ Hands Cold	☐ Pins & Needles in Legs	☐ Numbness in Toes	☐ Feet Cold
☐ Low Back Pain	☐ Hip Pain	☐ Knee Pain	☐ Constipation	☐ Diarrhea
☐ Urinary Problem	☐ Sleeping Problems	☐ Cold Sweats	☐ Other (describe):	
Since this accident occurred, are your symptoms:				
☐ Improving	☐ Getting Worse	☐ Same		
What are your PRESENT complaints and symptoms?				

POST ACCIDENT CARE			
Where were you taken after the accident?			
If taken to the hospital:			
How did you arrive?	☐ By ambulance	☐ Drove yourself	☐ Driven by a friend
Name of Hospital:			
How were you seen?	☐ Emergency Room Only	☐ Admitted to Hospital	
If admitted, how long did you stay at the hospital?			
What type of care did you receive?			
☐ Examination	☐ X-Rays	☐ Stitches	☐ Cervical collar
☐ Complete Bed Rest	☐ Prescription	☐ Physiotherapy	☐ Other
After release, did you return to:	☐ Work / School	☐ Home for Bed Rest	
Have you consulted any other physician?	☐ Yes	☐ No	If yes, please provide:
Doctor's name:	Phone #:	Address:	
Date of visit:	What care did you receive?		
Are you still under care?	☐ Yes	☐ No	
Since the accident, <u>are you</u>:			
☐ In need of live-in help to care for yourself	☐ Bedridden	☐ In need of assistance of a walker, wheelchair, cane or crutches	
☐ Walking with a limp	☐ Having psychological side effects	☐ Having anxiety while driving	
☐ Able to return to work	☐ Able to return to work on light duty only	☐ Unable to return to work	
Since the accident, <u>have you been unable to</u>:			
☐ Sleep	☐ Drive	☐ Resume daily activities	
☐ Exercise	☐ Other (please describe):		
Do you notice any restrictions in your activity as a result of this accident?	☐ Yes	☐ No	
If yes, please describe restrictions:			

LOST WAGES			
Have you lost time from work as a result of this accident?	☐ Yes	☐ No	If yes, please provide:
Type of employment:	Last day worked:	Compensation received for lost work:	

PRIOR ACCIDENTS			
Have you ever been involved in an auto accident before?	☐ Yes	☐ No	If yes, please provide:
Date:	Injuries sustained:		
Description of accident:			

PATIENT SIGNATURE	
Signature:	**Date:**