

Health Solutions

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Personal Injury Questionnaire

Welcome to our office. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in improving and maintaining your health.

Patient Information

Today's date: ____/____/____

Name _____ Social Sec. # _____ - _____ - _____
Last First Initial

Address _____ City _____ State _____ Zip _____

Phone #: (____) _____ - _____ Cell Phone #: (____) _____ - _____ Sex M F Age ____ Birth Date ____/____/____

Single Married Separated Divorced **Email address:** _____

Patient employed by _____ Occupation _____

Business Address _____ Business Phone # (____) _____ - _____

Whom may we thank for referring you to our office? _____

Notify in case of emergency _____ Relation _____ Phone (____) _____ - _____

Credit card #: _____ Type of card: AMEX VISA MC

Accident Information

Date of accident: _____

Who was the person at fault: _____ Do you have a police report: Y N Did the police issue a ticket: Y N

Your insurance company name: _____ Policy #: _____

Responsible party's Name: _____ Insurance Company: _____

Phone #: _____ Policy #: _____ Agents name: _____

Attorney name: _____ Attorney Phone #: _____

Nature of Accident

1. Date of Accident: _____ Time of day: _____
2. Were you: () Driver () Passenger () Front seat () Back seat 3. # of people in your car?: _____
4. Were you wearing a seat belt: Y N Describe how you were positioned in your seat upon impact:

5. What direction were you driving: North South East West on (name of street): _____
6. What direction was the other vehicle driving: North South East West on (name of street): _____
7. Were you struck from: Behind Front Left side Right side
8. Approximate speed of your car _____ mph. Other car _____ mph.

9. Did you ever lose consciousness? Y N Explain: _____

10. In your words describe the accident: _____

11. Please describe any complaints or symptoms you noticed:

a. Immediately after the accident: _____

b. Later that day: _____

c. The following day: _____

12. Describe your PRESENT complaints and symptoms: _____

13. Do you have any previous illnesses which relate to this case: _____

14. Where were you taken immediately after the accident: _____

15. Have you been treated by another doctor since the accident? () YES () NO If yes, please list doctor's name and phone number: _____

16. What type of treatment did you receive: _____

17. Since the injury occurred, are the symptoms: () Improving () Getting worse () Same

18. Check off the symptoms that you have noticed since the accident:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Pins & needles in arms | <input type="checkbox"/> Muscle tension | <input type="checkbox"/> Hands cold |
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Pins & needles in legs | <input type="checkbox"/> Muscle spasm | <input type="checkbox"/> Cold sweats |
| <input type="checkbox"/> Neck Stiff | <input type="checkbox"/> Head seems too heavy | where? | <input type="checkbox"/> Stomach upset |
| <input type="checkbox"/> Sleeping problems | <input type="checkbox"/> Numbness in arms / hands | <input type="checkbox"/> Loss of memory | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Numbness in legs/ feet | <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Irritability | <input type="checkbox"/> Fainting spells | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Feet cold | <input type="checkbox"/> Light bother eyes |
| <input type="checkbox"/> Jaw pain | <input type="checkbox"/> Shoulder pain | <input type="checkbox"/> Leg pain | <input type="checkbox"/> Loss of smell / taste |

Symptoms other than listed above: _____

19. Have you lost time from work as a result of this accident: () YES () NO

20. What type of work do you do: Sitting Standing Driving Other: _____

21. Do you notice any activity restriction as a result of this injury: () YES () NO If yes, please describe in detail:

23. List any medical conditions and Medications that you are currently taking : _____

Signature: _____

Date ____/____/____

****Payment is due in full at the time services are rendered unless prior arrangements have been approved.****