PERSONAL INJURY QUESTIONNAIRE

Name _____ Phone (_____)_____

Address _____ City _____ State _____ Zip _____

Age _____ Birth date _____ Sex: ☐ Female ☐ Male SS#_____

Employer's Name _____ Employer's phone number (_____)_____

Employer's Address _____

NATURE OF ACCIDENT:

1. Date of Accident _____ Type of Accident (Auto, Slip, Fall, etc.) _____
2. If auto, were you: ☐ Driver ☐ Passenger ☐ Front Seat ☐ Back Seat
3. Were you struck from: ☐ Behind ☐ Front ☐ Left Side ☐ Right Side
4. Approximate speed of your car _____mph
5. Were you knocked unconscious? ☐ Yes ☐ No If yes, for how long? _____
6. Were police notified? ☐ Yes ☐ No
7. In your own words, please describe accident in detail: (Draw picture if necessary) _____

_____

_____

8. Did you have any physical complaints BEFORE THE ACCIDENT? ☐ Yes ☐ No If not due to Auto please explain:

_____

_____

9. Please describe how you felt:
   a. DURING the accident: _____
   b. IMMEDIATELY AFTER the accident: _____
   c. LATER THAT DAY: _____
   d. THE NEXT DAY: _____
10. What are your PRESENT complaints and symptoms? _____

_____

11. Do you have any congenital (from birth) factors which relate to this problem? ☐ Yes ☐ No If yes, please describe:

_____

12. Do you have any previous illnesses which relate to this case? ☐ Yes ☐ No If yes, please describe: _____

_____

13. Have you ever been involved in an accident before? ☐ Yes ☐ No If yes, please describe, including date(s) and type(s) of accidents, as well as injur(ies) received: _____

_____

_____

14. Were you hospitalized after the accident? _____

15. Have you been treated by another doctor since the accident? ☐Yes ☐ No If yes, please list the doctor's name and address:

_____

What type of treatment did you receive? _____

16. Since this injury occurred, are your symptoms: ☐ Improving ☐Getting Worse ☐Same

17. CHECK THE SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT:

☐ Headache	☐ Irritability	☐ Numbness in Toes	☐ Face Flushed	☐ Feet Cold
☐ Neck Pain	☐ Chest Pain	☐ Shortness of Breath	☐ Buzzing in Ears	☐ Hands Cold
☐ Neck Stiff	☐ Dizziness	☐ Fatigue	☐ Loss of Balance	☐ Stomach Upset
☐ Sleeping Problems	☐ Head Seems Too Heavy	☐ Depression	☐ Fainting	☐ Constipation
☐ Back Pain	☐ Pins & Needles in Arms	☐ Lights Bother Eyes	☐ Loss of Smell	☐ Cold Sweats
☐ Nervousness	☐ Pins & Needles in Legs	☐ Loss of Memory	☐ Loss of Taste	☐ Fever
☐ Tension	☐ Numbness in Fingers	☐ Ears Ring	☐ Diarrhea	☐ _____

Symptoms Other Than Above: _____

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

19. Do you notice any activity restrictions as a result of this injury? ☐ Yes ☐ No If yes, please describe in detail: _____

_____

_____

ATTORNEY:

Name _____ Phone (_____) _____

Address _____ City _____ Zip _____

Patient's Auto Insurance

Name of Company _____

Policy # _____

Claim # _____

Billing Address _____

_____

Agent Name _____

Agent Phone Number (_____) _____

Patient's Health Insurance

Name of Company _____

Subscriber # _____

Date of Birth _____

Relationship to Patient _____

Policy # _____

Group # _____

Assignment and Release

I, the undersigned certify that I (or my dependent) have insurance coverage with the above stated insurance companies and assign directly to Shepherd Chiropractic all insurance benefits. I understand that **I am financially responsible for all charges whether or not paid by insurance.** I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____

Responsible Party Signature

_____

Relationship Date