

Smith Chiropractic and Rehabilitation Center

Dr. John Smith

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www.SmithChiro.info

PERSONAL INJURY QUESTIONNAIRE

TO SAVE TIME AND ALLOW US TO BETTER SERVE YOU PLEASE COMPLETE ALL QUESTIONS

PATIENT/INSURED'S INFORMATION

Patient Last Name	First Name	M.I.	Date of Birth	Social Security Number	<input type="checkbox"/> M	<input type="checkbox"/> F
Insured's Last Name	First Name	M.I.	Date of Birth	Social Security Number	<input type="checkbox"/> M	<input type="checkbox"/> F
Insured's Address	City	State	Zip Code	Phone Number		

INSURANCE COMPANY

Primary Insurance Carrier	Policy #	Claim#		
Address	City	State	Zip Code	Ins. Co. Phone Number
Secondary Insurance Carrier	Policy #	Claim#		
Address	City	State	Zip Code	Ins. Co. Phone Number

ATTORNEY INFORMATION

Attorney Name	Phone Number	Fax Number	
Address	City	State	Zip Code

ACCIDENT INFORMATION

What type of Injury? <input type="checkbox"/> Auto Accident <input type="checkbox"/> Work Comp. <input type="checkbox"/> Other	Date of Injury:	Time of Injury: <input type="checkbox"/> AM <input type="checkbox"/> PM	Date of First Treatment:
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HISTORY OF INJURY:

In your own words, please briefly describe your how the accident happened:

PREVIOUS CONDITIONS AND TREATMENT:

In your own words, please list any previous accidents, injuries, or conditions which may have contributed to your present complaints: _____

PLEASE TURN OVER

Auto Accident Info

- **What was your position in the vehicle?**
 Driver Front Passenger Rear Passenger Pedestrian (not in car)
- **What type of vehicle were you driving or riding in?**
 Compact Car Mid Size Car Full Size Car Compact Truck
 Full Truck Mini Van Full Size Van Small SUV
 Lg. SUV Motorcycle Motor Home Bicycle
- **Make and model of vehicle:** _____
- **What was your vehicle doing just prior to the accident?**
 Stopped at a stop light Slowing down to a stop
 At a complete stop Increasing speed
 Merging into traffic Changing Lanes Other _____
- **You were traveling at an approximate speed of _____ mph.**
- **Who hit who?**
 You were struck by another car Struck another car
 You struck a stationary object Other _____
- **How were the weather conditions?**
 Sunny Hazy Rain Sleet
 Snow Fog Other _____
- **What was your vehicle's point of impact? (mark all that apply)**
 Front Rear Right Side Left Side
 Right Front Left Front Right Rear Left Rear
- **What was the other vehicle doing just prior to the accident?**
 Stopped at a stop light Slowing down to a stop
 At a complete stop Increasing speed
 Merging into traffic Changing Lanes Other _____
- **The other vehicle was traveling at an approximate speed of _____ mph.**
- **What was the other vehicle's point of impact? (mark all that apply)**
 Front Rear Right Side Left Side
 Right Front Left Front Right Rear Left Rear
- **Were you wearing seat restraints?**
 Full lap and shoulder restraint Lap restraint only
 Shoulder restraint only Was not wearing a restraint
- **What position were your vehicle's head rests in?**
 Lowest position Middle position
 Highest position No head rest in vehicle
- **Did your vehicle's air bags deploy?**
 Yes No Vehicle not equipped with air bags
- **Were you prepared for the impact?**
 Came as a complete surprise Aware and braced for the collision
 Aware but not braced for the collision Other _____
- **What position was your head and neck in prior to the impact?**
 Straight forward Rotated to the left Rotated to the right
 Turned around Turned around Toward the rear view mirror
- **What happened to your body at the moment of impact?**
 Body was tensed for impact Body whipped forward/backward
 Body torqued and twisted Body was thrown over seat
 Body was thrown from vehicle Body was pinned in vehicle
 Body was thrown from side to side Body was cut and bruised
- **What was your mental/emotional state immediately following?**
 Unconscious Shaken up
 Disoriented Shaken up & Disoriented
- **Did you receive medical attention at the scene of the accident?**
 Yes No
- **Where did you go immediately following the accident?**
 Home Personal Doctor This office Resumed daily activities
 Hospital (if selected, please answer next question)
- **How did you get to the hospital?**
 Ambulance Friend/Family member Other _____
- **Do you have hospital records?**
 Yes No
- **Do you work:**
 Full time Part time Student Retired
- **How many days were missed from work and/or school following the accident?** _____
- **To your best knowledge, please list any part of your body that may have struck any part of the vehicle. (For example: Right arm hit dashboard)**

Workers Comp Info

If your injury involved LIFTING, complete this section:

- **From where were you lifting an object?**
 Ground level A surface below ground level
 A surface 1 to 3 feet high A surface 3 to 5 feet high
- **How many pounds was the object you were lifting?**
 1 to 5 pounds 5 to 10 pounds 10 to 20 pounds
 20 to 40 pounds 40 to 60 pounds Over 60 pounds
- **What position were you in while lifting the object?**
 Back was upright and straight Bent over at the waist
 Twisted to the left side Twisted to the right side
- **What type of pain did you feel immediately after the injury?**
 Gripping pain Sharp pain Dull pain
 Aches Popping feeling Paralysis

If your injury involved Falling, complete this section:

- **From where did you fall at work?**
 Onto the ground while walking Onto the ground while running
 From 1 to 3 feet high From 3 to 5 feet high
 From 5 to 8 feet high From higher than 8 feet
- **What part of your body did you land on?**
 Head Neck Right Shoulder Left Shoulder
 Right Arm Left Arm Right Hand Left Hand
 Back Right Buttock Left Buttock Tail Bone
 Right Hip Left Hip Right Leg Left Leg
 Right Knee Left Knee Right Foot Left Foot
- **What other areas of your body were affected by you fall?**
 Head Neck Right Shoulder Left Shoulder
 Right Arm Left Arm Right Hand Left Hand
 Back Right Buttock Left Buttock Tail Bone
 Right Hip Left Hip Right Leg Left Leg
 Right Knee Left Knee Right Foot Left Foot

Other work related injuries:

- Raised up from bending over Twisted at the waist
 Wrist injury from repetitive use Wrist injury from pulling
(Please describe all injuries in your own words on page 1 of this form)

Job analysis information:

- **What regular activities do you perform at work? (Please mark all that apply)**
 Sitting Standing Walking
 Running Driving Lifting
 Bending/Stooping Squatting Crawling
 Climbing Crouching Kneeling
 Reach above Shoulders Pushing/Pulling
 Maintain awkward position
- **How much do you regularly lift at work?**
 Little to none 1 to 10 Lbs 10 to 20 Lbs 20 to 40 Lbs
 40 to 60 Lbs 60 to 80 Lbs 80 to 100 Lbs Over 100 Lbs
- **Do you regularly bend over while lifting?** Yes No
- **Are your hands subject to any of the below repetitive movements?**
 Light grasping (left hand/Right Hand/Both) (Please circle one)
 Firm grasping (left hand/Right Hand/Both) (Please circle one)
 Typing Using a computer mouse
- **How many hours do you regularly perform the below activities?**
Sitting: 1-2 hours 2-4 hours 4-6 hours 6-8 hours
Standing: 1-2 hours 2-4 hours 4-6 hours 6-8 hours
Walking: 1-2 hours 2-4 hours 4-6 hours 6-8 hours
Lifting: 1-2 hours 2-4 hours 4-6 hours 6-8 hours