JOURNEY
FAMILY CHIROPRACTIC

PERSONAL INJURY QUESTIONNAIRE

NAME: _____ Date of Accident_____

Where did accident happen? Describe the accident in your own words:

What was your position in the car?

Driver: if Driver were your hands on the steering wheel? Left Right Both

Passenger: If passenger, were you sitting in Front Right Rear Left Rear

Did your vehicle strike another vehicle Yes No

Was your vehicle struck by another vehicle Yes No

Angles of impact… First Collision: Front Back Left Right

If Second Collision: Front Back Left Right

Were you wearing a seat belt? Yes No

Did you brace for impact? Yes No … I braced with my hands I braced with my feet

Which way were you facing at the time of impact… straight ahead Left Right

Did you strike anything in vehicle at time of impact? Yes No

If yes, specify what part of your body struck what: ie… head chest chin shoulder Right / Left Knee

Steering Wheel _____ Dashboard _____

Windshield _____ Roof_____

Left Side Door _____ Right Side Door_____

Left Side Window. _____ Right Window _____

Other _____

Did the seat back bend / break ? Yes No

Immediately following the accident, how did you feel? dizzy/dazed disoriented unconscious

nervous nauseous upset weak Other _____

Did you go to hospital Yes No Were you admitted to the hospital? Yes No if yes how long? _____

If you went to hospital, when? At time of accident Next day

How did you get to hospital? Ambulance Police Car Private Transportation

Name of Hospital:_____

Attended by Dr. _____

… what treatment was given?

☐none ☐placed in a cervical collar ☐x-rayed ☐ given stitches ☐Bandaged

☐ given pain medication ☐given instructions regarding concussions

☐given instructions regarding sprains and strains ☐ Physical Therapy

☐instructed to call a Orthopedic Surgeon ☐instructed to call a private physician

☐referred to this office for treatment ☐ Other _____

_____

Have you seen any other doctor as a result of this accident? Yes No

Doctor's name

CHIEF Complaints or Symptoms: **Name:** **Date:**

☐ **Neck pain** ☐none ☐left shoulder ☐left arm ☐left forearm ☐left hand
check off the areas that the pain ☐right shoulder ☐right arm ☐right forearm ☐right hand
runs into from the neck

☐headache
☐Migraine Headache
☐upper back pain

Ringing in Ears	☐Yes ☐No	☐Left	☐Right	☐Both Ears	
Blurry Vision	☐Yes ☐No	☐Left	☐Right	☐Both Eyes	
Wrist Pain	☐Yes ☐No	☐Left	☐Right	☐Both Wrists	
Jaw Pain	☐Yes ☐No	☐Left	☐Right	☐Both Sides	

☐Dizziness ☐nervousness ☐fatigue ☐anxiety ☐depression ☐excessive irritability
☐fear of driving in a car ☐a loss of concentration ☐jaw clenching ☐grinding of teeth at night ☐
nightmares ☐difficulty with sleeping at night

☐ **Low Back Pain** ☐none ☐buttocks ☐left buttock ☐left thigh ☐left knee
select the areas of radiation, if any... ☐left foot ☐right buttock ☐right thigh ☐right knee ☐right foot

Hip Pain	☐ Left	☐Right	☐Bilateral
Knee Pain	☐ Left	☐Right	☐Bilateral
Foot Pain	☐ Left	☐Right	☐Bilateral

Numbness:

☐ Left Hand	☐Left Upper Arm	☐Right Hand	☐Right Upper Arm
☐ Left Foot	☐Left Leg	☐Right Foot	☐Right Leg

Additional Symptoms/ Complaints:

Have You lost any time from work due to your injuries? Yes No
If yes please give dates: _____
Type of employment:
_____
Have you had previous injuries or accidents? Yes No
Description of previous Accident: _____
Description of previous injuries: _____
Is there any residual pain from the previous injury? Yes No
How much better did you feel prior to your current condition? (Example 100%, 80% etc.) _____

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