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Name:
Date of Birth:
Date:

Personal Injury Questionnaire

Referred by:

1. Date of Accident Time of day Road Conditions

In your own words, please describe the accident:

- 2. Were you: () Driver () Passenger - in the () front seat () back seat.
Wearing a seatbelt? shoulder strap
3. What make and model of car were you driving? other vehicle?
Number of people in your car: Were other people injured?
4. What direction were you headed? () North () South () East () West on (name of street)
5. What direction was other vehicle headed? () North () South () East () West on (name of street)
6. Were you struck from: () Behind () Front () Left side () Right side. What is your property damage:
7. Did your vehicle strike another vehicle or object? If yes, explain:
8. Did you lose consciousness? () yes () no. If yes, how long: Was there a police report? () yes () no
9. At the time of the impact were you () looking straight ahead? () looking right? () looking left? () other

10. Did you strike anything in the vehicle? () yes () no If yes, please give details:

11. Were you aware that you were going to be in a collision? () yes () no Did you brace yourself?

- 12. Please describe how you felt:
a. During the accident:
b. Immediately after the accident:
c. Later that day:
d. The next day:

13. What are your present complaints and symptoms:

14. Where were you taken 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:

16. What type of treatment did you receive?

17. Did you have any physical complaints BEFORE the accident? () yes () no If yes, please describe in detail:

18. Do you have any previous illnesses or hereditary factors that relate to this case? () yes () no. If yes, please describe:

19. 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 injuries received: _____

20. Since the injury occurred, are your symptoms: () improving () getting worse () same
Check symptoms you have noticed since the accident:

- | | | | | |
|-------------------------|--------------------------|-------------------------|---------------------|------------------------------|
| () Headache | () fatigue | () Nervousness | () Buzzing in ears | () constipation |
| () Irritability | () sleeping problems | () Ears ring | () loss of balance | () cold sweats |
| () Neck stiff | () Head seems top heavy | () Face flushed | () fainting | () Pins and needles in legs |
| () Dizziness | () Light sensitivity | () Loss of memory | () Loss of smell | () Pins and needles in arms |
| () Neck Pain | () Depression | () Tension | () Loss of taste | () Numbness in toes |
| () Chest Pain | () back pain | () Numbness in fingers | () Fever | () _____ |
| () Shortness of breath | | | | () _____ |

21. Have you lost time from work as a result of this accident? () yes () no
a. Last day worked: _____
b. Type of employment: _____
c. Are you being compensated for time lost from work? () yes () no. If yes, please state compensation: _____

22. Do you notice any activity restrictions as a result of this injury? () yes () no. If yes, please describe in detail: _____

23. Other pertinent information: _____

Please draw a picture of the accident:

Date

Patient's Signature