

PERSONAL INJURY QUESTIONNAIRE

Cornerstone Chiropractic Inc. PS 2003 132nd Street SE, Ste. E, Everett, WA 98208 (425) 379-6301

Name: _____ Date of Accident _____ Time _____ AM or PM

Location of Accident: _____

Intersecting with: _____

Police Investigation by:

- Washington State Patrol
- _____ City Police
- _____ County Police
- Other _____
- No investigation

Road Conditions: Wet Dry Ice Snow

Other-Describe _____

Where were you seated in the vehicle? _____

Were you aware of the approaching collision prior to impact or did the impact catch you by surprise?

Did you lose consciousness (blackout) upon impact? _____

If yes, can you estimate for how long? _____

How far is the top of your headrest from the top of your head?

Approximately _____ inches above Approximately _____ inches below

Were you struck from: Behind Front Left side Right Side

Were you wearing a seat belt? Yes No

If yes, what type? Lap belt only Shoulder and Lap belt

Is your car equipped with air bags? Yes No If yes, did they inflate? Yes No

Was your car stopped at the time of impact? Yes No

If yes, was the driver's foot on the brake? Yes No

If no, estimate the speed of the vehicle you were in: _____ MPH

If your vehicle was moving at the time of impact, was it:

slowing down gaining speed or traveling at a steady rate at the time of impact?

Number of people in your vehicle: _____

Please describe, the best of your knowledge, what happened during this accident:

What type of vehicle were you in? (Year, Make, Model) _____

Year, Make and Model of other vehicle? _____

Was the other vehicle moving at the time of collision? Yes No, If yes, approximate speed? _____ MPH

If the other vehicle was moving at the time of collision, was it:

slowing down gaining speed or traveling at a steady rate at the time of impact?

Was your vehicle pushed forward upon impact? Yes No If yes, how much?

More than one car length One Car length ½ car length Less than ½ car length Not at all

Did your car hit anything else after it was hit? _____

Describe the damage to the vehicle _____

Which of the following car parts broke during the accident?

Windshield Steering wheel Right/Left side window Front seat Other

What bruises or cuts did you get from this accident? _____

On what part of the automobile did the following body parts hit;

Head _____ Chest _____

Left Shoulder _____ Right Shoulder _____

Left Arm _____ Right Arm _____

Left Hip _____ Right Hip _____

Left Leg _____ Right Leg _____

Left Knee _____ Right Knee _____

Other _____

What position was your head facing upon impact? _____

Indicate the symptoms resulting from the accident:

<input type="checkbox"/> Neck pain	<input type="checkbox"/> Numb hands/fingers	<input type="checkbox"/> Nausea	<input type="checkbox"/> Memory Loss
<input type="checkbox"/> Mid back pain	<input type="checkbox"/> Shoulder pain	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Tension
<input type="checkbox"/> Low back pain	<input type="checkbox"/> Numb toes/feet	<input type="checkbox"/> Chest pain	<input type="checkbox"/> Difficulty sleeping
<input type="checkbox"/> Headaches	<input type="checkbox"/> Leg pain	<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Irritability
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Jaw problems	<input type="checkbox"/> Ringing in ears	<input type="checkbox"/> Blurred Vision

Other _____

When did your pain begin? _____

Is your condition getting worse? Yes No _____

As time progresses, have any other problems appeared? Yes No _____

After the accident did you go to the hospital or another doctor? _____

Describe any treatment you received: _____

Have you been able to work since the accident? Yes No Time lost from work: _____ days

What are your daily work duties? _____

Are your work activities restricted as a result of this injury (describe)? _____

Normal work day: _____ hours While in recovery, is there any light work you could request? Yes No

Have you retained an attorney? Yes No Name of attorney _____ Phone _____

I understand the above and guarantee this form was completed to the best of my knowledge.

PATIENT SIGNATURE _____ DATE _____

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