PERSONAL INJURY QUESTIONNAIRE

Cornerstone Chiropractic 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 that 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:

❑Neck pain	❑Numb hands/fingers	❑Nausea	❑Memory Loss
❑Mid back pain	❑Shoulder pain	❑Fatigue	❑Tension
❑Low back pain	❑Numb toes/feet	❑Chest pain	❑Difficulty sleeping
❑Headaches	❑Leg pain	❑Shortness of breath	❑Irritability
❑Dizziness	❑Jaw problems	❑Ringing in ears	❑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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