Holistic Health & Chiropractic of Frankfort
Jon K. Heyer, D.C.

Personal Injury/Accident Questionnaire

Name_____ **Date**_____

Date of Accident _____ **Time of Accident**_____

Driver of car _____ **Where were you seated?** _____

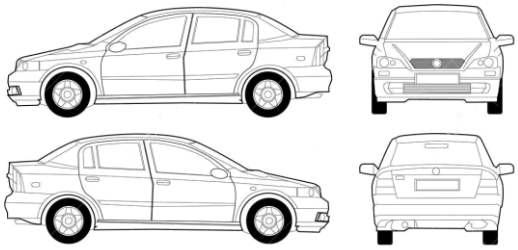
Who owns the car? _____ **Year/Model of the car** _____

Year/Model of other car _____

What was the approximate damage done to your car? _____ **($** _____**)**

Visibility at time of accident: [ ] Poor [ ] Fair [ ] Good [ ] Other _____

Where was your car struck?



In your own words describe accident _____

_____

Type of accident: [ ] Head on collision [ ] Broad side collision [ ] Front impact [ ] Rear end car in front
[ ] Rear impact [ ] Non collision

What parts of your head or body hit what parts on the inside of your car at time of accident? _____

_____

Did you see the accident coming? [ ] Yes [ ] No Did you brace for impact? [ ] Yes [ ] No

Were seatbelts worn? [ ] Yes [ ] No Were shoulder harness worn? [ ] Yes [ ] No

Does your car have headrests? [ ] Yes [ ] No If yes, what was the position of headrests compared to your head before the accident?

[ ] Top of headrest even with bottom of head
[ ] Top of headrest even with top of head
[ ] Top of headrest even with middle of neck

Was your car braking? [ ] Yes [ ] No Was your car moving at the time of accident? [ ] Yes [ ] No
If yes, how fast would you estimate you were going? _____ **Mph**

How fast would you estimate the other car was going? _____ **Mph**

Head/body position at time of impact:

[ ] Head turned left/right **[ ] Body straight in sitting position** **[ ] Head looking back**
[ ] Body rotated left/right **[ ] Head straight forward** **[ ] Other**

As a result of the accident were you:

[ ] Rendered unconscious **[ ] In shock** **[ ] Dazed, circumstances vague**
[ ] Other

How was the shoulder harness adjusted? [ ] Loose [ ] Snug

Were you wearing a hat or glasses? [ ] Yes [ ] No

Could you move all parts of your body? [ ] Yes [ ] No

If no, what parts couldn't you move and why? _____

Were you able to get out of the car and walk unaided? [ ] Yes [ ] No

If no, why not? _____

Did you get any bleeding cuts? [ ] Yes [ ] No Where? _____

Did you get any bruising? [ ] Yes [ ] No Where? _____

Please describe how you felt after the accident:

Immediately after the accident _____

Later that day _____

The next day _____

Check symptoms apparent since the accident:

[ ] Headache	**[ ] Neck pain/stiffness**	**[ ] Midback pain**	**[ ] Eyes light sensitive**
[ ] Pain behind eyes	**[ ] Dizziness**	**[ ] Fainting**	**[ ] Sleeping problems**
[ ] Numbness in finger	**[ ] Numbness in toes**	**[ ] Loss of smell**	**[ ] Loss of taste**
[ ] Loss of memory	**[ ] Fatigue**	**[ ] Breath shortness**	**[ ] Irritability**
[ ] Depression	**[ ] Ringing/buzzing**	**[ ] Loss of balance**	**[ ] Tension**
[ ] Cold hands	**[ ] Cold feet**	**[ ] Diarrhea**	**[ ] Constipation**
[ ] Chest pain	**[ ] Nervousness**	**[ ] Cold sweats**	**[ ] Anxious**
[ ] Facial pain	**[ ] Clicking of popping jaw**		

[ ] Other _____

Occupation _____ **Employer** _____

Have you missed time from work? [ ] Yes [ ] No If yes, time off work from _____ **to** _____

Did you seek medical help immediately after the accident? [ ] Yes [ ] No

If yes, how did you get there? [ ] Ambulance [ ] Police [ ] Someone else drove me [ ] Drove own car [ ] Other _____

Doctor 1 Name _____ First visit date _____

Were you examined? [ ] Yes [ ] No Were x-rays taken? [ ] Yes [ ] No

Did you receive treatment? [ ] Yes [ ] No [ ] Medications [ ] Braces [ ] Collars

What kind of treatment did you receive? _____

What benefits did you receive from treatment? _____

Date of last treatment _____

Doctor 2 Name _____ First visit date _____

Were you examined? [ ] Yes [ ] No Were x-rays taken? [ ] Yes [ ] No

Did you receive treatment? [ ] Yes [ ] No [ ] Medications [ ] Braces [ ] Collars

What kind of treatment did you receive? _____

What benefits did you receive from treatment? _____

Date of last treatment _____

System review (Please check all symptoms that apply):

[ ] Bladder trouble	**[ ] Excessive urination**	**[ ] Scanty urination**	**[ ] Painful urination**	**[ ] Discolored urine**
[ ] Poor appetite	**[ ] Excessive hunger**	**[ ] Difficulty chewing**	**[ ] Difficulty swallowing**	**[ ] Excessive thirst**
[ ] Nausea	**[ ] Vomiting food**	**[ ] Abdominal Pain**	**[ ] Diarrhea**	**[ ] Constipation**
[ ] Black stool	**[ ] Bloody stool**	**[ ] Hemorrhoids**	**[ ] Liver trouble**	**[ ] Gall bladder trouble**
[ ] Weight trouble				
[ ] Numbness	**[ ] Loss of feeling**	**[ ] Paralysis**	**[ ] Dizziness**	**[ ] Fainting**
[ ] Headaches	**[ ] Muscle jerking**	**[ ] Convulsions**	**[ ] Forgetfulness**	**[ ] Confusion**
[ ] Depression				
[ ] Chest Pain	**[ ] Pain over heart**	**[ ] Difficulty breathing**	**[ ] Persistent cough**	**[ ] Coughing phlegm**
[ ] Coughing blood	**[ ] Rapid heartbeat**	**[ ] High blood pressure**	**[ ] Heart problems**	**[ ] Lung problems**
[ ] Varicose veins	**[ ] Other**			
[ ] Eye strain	**[ ] Eye inflammation**	**[ ] Vision problems**	**[ ] Ear pain**	**[ ] Ear noises**
[ ] Ear discharge	**[ ] Hearing loss**	**[ ] Nose pain**	**[ ] Nose bleeding**	**[ ] Nose discharge**
[ ] Sore gums	**[ ] Sore mouth**	**[ ] Sore throat**	**[ ] Hoarseness**	**[ ] Speech difficulty**
[ ] Dental problems				

Patient Signature _____ Date _____