CHIROMAX WELLNESS CENTERS

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: i.e.... 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 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 for treatment ☐ Other _____

_____

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

Doctor's Name:
