HATFIELD CHIROPRACTIC & REHAB CENTER

PERSONAL INJURY QUESTIONNAIRE

Please complete entire form. Date ___________________

Name ____ Date of Birth: ____________________

Address: ____ Phone: ________________________

Person responsible for account: ❑ Self ❑ Spouse ❑ Parent/Guardian Relationship (if guardian) _________________

Name ______________________________________ SSN: ______________________ DL#: ___________________

Address____ City/State/ZIP: ________________________

Home Phone: _____________ Work Phone: _____________ Cell Phone: _____________ Date of Birth: __________

ATTORNEY INFORMATION:

Attorney ______________________________________ Firm Name ____

Address _______________________________ City/Sate/ZIP______________________ Phone ____________________

YOUR AUTO INSURANCE INFORMATION (Please present Auto Insurance Card):

Insurance Company ____________________________ Policy # _______________ Agent: ______________________

Insured Name _____________________________ Insured Phone _________________ Insured Date of Birth __________

Adjustor: ___________________________________ Claim #____________________ Phone: _______________________

THIRD PARTY INFORMATION:

Responsible Party's Name ____ Phone _______________________

Address ____ City/State/ZIP___________________________

Policy Holder's Name ____ Policy # _____________________

Adjustor: ___________________________________ Claim #____________________ Phone: _______________________

ACCIDENT INFORMATION:

Type of Accident: ❑ Vehicle Collision ❑ Other ____

Date of Accident: _____________ Time: __________ ❑am ❑pm City/State: __________________________________

What direction were you headed? ❑ North ❑ East ❑ South ❑ West on _____________________________________

What direction was other vehicle headed? ❑ North ❑ East ❑ South ❑ West on ______________________________

Make, model, and year of the vehicle <u>you</u> were in: ____

Number of people in your vehicle: ______ Names: ____

What portion of your car was impacted? ❑ Rear ❑ Front ❑Left side ❑ Right side

Where were you located inside the vehicle? ❑Driver ❑Front Passenger ❑Rear Passenger

During impact, were you facing: ❑ Forward ❑ Right ❑ Left Were you: ❑ aware of the impact ❑ surprised

Was your car: ❑Stopped or ❑Moving ______ MPH Were you wearing a seat belt? ❑ No ❑ Yes

Was the vehicle equipped with airbags? ❑ No ❑ Yes Did the airbags inflate? ❑ No ❑ Yes

In relation to the base of your skull, where was the headrest? ❑ Above ❑ Below ❑ At the Base

Did your hat/glasses fall from your head during the accident? ❑ No ❑ Yes

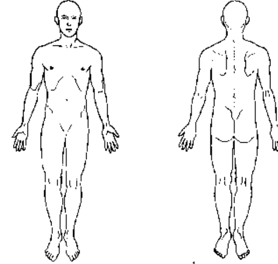
Did any other part of your body strike anything in the vehicle? ❑ No ❑ Yes ____

What did your vehicle hit? ❑ Nothing ❑ A vehicle ❑ Other ____

Was your car totaled? ❑ No ❑ Yes

Where did you notice immediate pain or symptoms?

Please mark with an "X"



Since the accident, are your symptoms: ❑ Better ❑ Worse ❑Same

Were you knocked unconscious? ❑ No ❑ Yes For how long? ____

Did you go to the hospital/ER? ❑ No ❑ Yes If no, where did you go? __________________________________

If yes, when did you go to the hospital? ❑ Immediately ❑ Next Day ❑ 2 Days +

Name/location of hospital/ER ____

Did you go by ambulance? ❑ No ❑ Yes

Did the EMT give you medications or supplies? ❑ No ❑ Yes Please list: ____________________________________

If you went to the hospital:

Were you there overnight? ❑ No ❑ Yes Medications received? ____

Were X-rays taken? ❑ No ❑ Yes What areas? ____

What were the treating doctor's recommendations? ____

Since the accident, have you been to any other doctors? ❑ No ❑ Yes Name/location: ________________________

Were police notified? ❑ No ❑ Yes Was a police report filed? ❑ No ❑ Yes Where? ________________________

Was a traffic violation issued? ❑ No ❑ Yes To whom? ____

In your own words, describe the accident. ____

____

Have you lost time from work as a result of this accident? ❑ No ❑ Yes Last Day Worked ________________

____

Patient Name

____ ____________________________________

Patient Signature (Parent/Legal Guardian if patient is a minor) Date