

HATFIELD CHIROPRACTIC & REHAB CENTER

PERSONAL INJURY QUESTIONNAIRE

Please answer every question. If something does not apply to you, write "N/A". 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/State/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 you 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

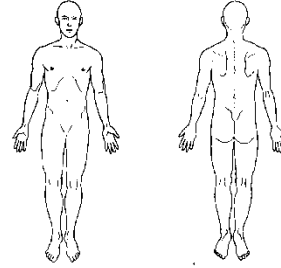
Did any other part of your body strike anything in the vehicle? No Yes _____

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