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/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 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

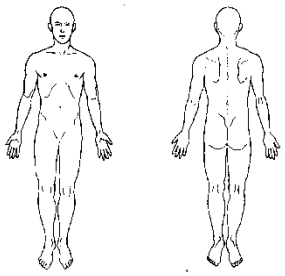
Did any other part of your body strike anything in the vehicle? ☐ No ☐ Yes _____

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