

Personal Injury Questionnaire

(Please Print)

Date: _____ Cell: (____) _____ Home: (____) _____

Patient: _____

Last Name

First Name

MI

Responsible Party (if a minor) _____

Street Address _____

City _____ State _____ Zip _____

Sex: M F Age _____ Birthdate _____ SSN _____

Single Married Widowed Separated Divorced

Employed Full-time Student Part-time Student

Patients School Name _____

Patient Employed By _____

Business Address _____

Occupation _____

Name of your Auto Insurance _____

Policy # _____ Claim# _____

Does your policy have: Med. Pay _____ Uninsured Motorist _____

Adjuster _____ Phone (____) _____

Address _____

Name of driver of other car _____

Other drivers' insurance _____

Policy # _____ Claim# _____

Adjuster _____ Phone (____) _____

Address _____

Date and time injury occurred: Month _____ Day _____ Year _____ Time _____ am/pm

Give all details of how your accident occurred: _____

Name: _____

Have you retained an attorney? Yes No

If yes, give name and phone _____ Phone (____) _____

Were the police notified? Yes No

Were you knocked unconscious? Yes No If yes, how long? _____

Was any other doctor consulted after your accident? Yes No

If yes, name _____

Have you ever been injured in this same area before? Yes No

If yes, please explain _____

Before this injury were you able to work on an equal basis with others your age? Yes No

Has this accident restricted your work performance? _____

In what exact area did you feel pain immediately after the accident? _____

What treatment did you receive? _____

At the time of the accident, what direction were you going? North South East West

on _____ Street _____ Highway _____

Direction other vehicle strike you from the: Front Back Left side Right side

Were you the: Driver Passenger

If passenger were you in the: Front seat Back seat

Were you wearing a seatbelt? Yes No

Did you anticipate the collision? Yes No

Since this injury are your symptoms: Same Better Worse

Were you wearing glasses? Yes No If so, were they thrown? _____

Did impact throw anything around in the vehicle? Yes No _____

Which way were you looking at point of impact? _____

How many cars were involved in the accident? _____

How much damage was done to your car? _____

How much damage was done to other car? _____

Was anyone else with you? Yes No _____

Any witnesses to the accident? Yes No _____

What was your speed at the time of the accident? _____

What was the other cars speed? Estimate _____

Were you taken to the emergency room? Yes No

If yes, were you admitted? Yes No Recommendations: _____

List any other doctors seen and their recommendations: _____

How frequent do you urinate since the accident? _____

Is there blood in the urine? _____

What kind of work do you do? _____

Do you do any heavy lifting or bending? _____

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with _____ and assign directly to Dr. Jerry L. Johnson, Johnson Family Chiropractic Clinic, P.C., all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorized the use of this signature on all my insurance submissions whether manual or electronic.

Signature of Patient/Guardian

Date