

DAY CHIROPRACTIC CLINIC, P.S.

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PERSONAL INJURY QUESTIONNAIRE

Patient Name _____ Date _____

Birthdate _____ Age _____ Sex: M F

YOUR insurance company ? _____ Policy # _____

Do you have **Personal Injury Protection (PIP)** on your policy? Y N **Claims Adj** _____
Have you opened a claim? Claim Number _____

Other driver/vehicle insurance company? _____

Have you retained an **attorney**? Y N If yes, name and number of attorney _____

NATURE OF ACCIDENT:

Date of accident _____ Time of Day _____ am / pm City, St _____

Were **you**: () Driver () Passenger * () Front Seat () Back Seat

Number of people in your vehicle? _____ Other vehicle? _____

What direction were **you** headed? () North () South () East () West
On (name of street) _____ intersecting with _____

What direction was **other** vehicle headed? () North () South () East () West
On (name of street) _____ intersecting with _____

What type of vehicle were **you** driving? () Compact Car () Mid Size Care () Full Size Car
() Compact Truck () Full Truck () Mini Van () Full Size Van () Small Sport Utility
() Large Sport Utility () Motorcycle () Motor Home () Bicycle () Other _____

What was **your** vehicle doing just prior to the accident? () Stopped at a stop light () At a complete stop
() Slowing down to a stop () Merging in traffic () Increasing speed () Changing Lanes

Traveling at an approximate speed of: _____ mph

Who hit who? () You were struck by another car () You struck another car () You struck a stationary object

What was **your** vehicles point of impact? () Front () Right Front () Rear () Left Front () Right Side
() Right Rear () Left Side () Left Rear

What was **the other** vehicle doing just prior to the accident? () Stopped at a stop light () At a complete stop
() Slowing down to a stop () Merging in traffic () Increasing speed () Changing Lanes

Traveling at an approximate speed of: _____ mph

Patient Name _____

What was **the other** vehicles point of impact? () Front () Right Front () Rear () Left Front
() Right Side () Right Rear () Left Side () Left Rear

Were **you** wearing seat restraints? () Full lap and shoulder restraint () Shoulder restraint only
() Lap restraint only () I was not wearing a restraint

What position were **your** vehicles head rests in? () Lowest Position () Middle Position () Highest Position
() No head rest in vehicle

Did **your** vehicles air bags deploy? () Yes () No

Were **you** prepared for the impact? () Came as a complete surprise () Aware but not braced for impact
() Aware and braced for impact

What position was **your** head and neck in prior to the impact? () Straight forward () Tilted forward
() Rotated to the left () Rotated to the right () Turned around () Toward rear view mirror

What happened to **your** body at the moment of impact? () Tensed for impact () Torqued and Twisted
() Thrown from vehicle () Thrown from side to side () Whipped forward/backward () Thrown over seat
() Pinned in vehicle () Cut and bruised

What was **your** mental/emotional state immediately following? () Unconscious () Disoriented
() Shaken Up () Shaken up and Disoriented

Were the police notified? () Yes () No Police report number _____

In your own words, please describe the accident _____

Did any areas of your body strike any part of your vehicle? () yes () No If yes, please describe _____

Did you have any physical complaints BEFORE THIS ACCIDENT? () yes () No If yes, please describe _____

Please describe how you felt:

During the accident _____

Immediately after the accident _____

Later that day _____

The next day _____

Patient Name _____

What are your PRESENT complaints and symptoms? _____

Do you have any congenital (from birth) factors which relate to this problem? () Yes () No

If yes, please describe _____

Do you have any previous illnesses which relate to this case? () Yes () No If yes, please describe _____

Have you ever been involved in an accident before? () Yes () No If yes, please describe, including date(s) and type(s) of accidents, as well as injury(ies) received. _____

Where were you taken after **THIS** accident? _____

Have you been treated by another doctor since **THIS** accident? () Yes () No

If yes, please describe _____

Since this injury occurred, are your symptoms () Improving () Getting worse () Same

Please **circle** symptoms you have noticed since accident:

Headache	Irritability	Numbness in toes	Face flushed	Feet cold
Neck pain	Chest pain	Shortness of breath	Buzzing in ears	Hands cold
Neck stiff	Dizziness	Fatigue	Loss of balance	Stomach upset
Sleeping problems	Head seems heavy	Depression	Fainting	Constipation
Back pain	Pins/needles in arms	Lights bother eyes	Loss of smell	Cold sweats
Nervousness	Pins/needles in legs	Loss of memory	Loss of taste	Fever
Numbness in fingers	Ears ringing	Diarrhea	Tension	

Symptoms other than above _____

Have you lost time from work as a result of this accident? () Yes () No If yes, please describe:

Last day worked: _____

Type of employment: _____

Do you notice any activity restrictions as a result of this injury? () yes () No

If yes, please describe _____

Other pertinent information the doctor needs to be aware of? _____

Patient's Signature/Guardian Signature

Date