Bradbury Chiropractic Clinic

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PERSONAL INJURY QUESTIONAIRE

NAME_____ DATE OF BIRTH_____ PHONE # ( )_____
ADDRESS_____ CITY _____ STATE _____ ZIP _____
EMPLOYER'S NAME _____ ADDRESS_____
DATE OF INJURY_____

YOUR INSURANCE INFORMATION:
INSURANCE COMPANY _____ INSURED NAME _____
CLAIMS MANAGER _____ TELEPHONE # ( ) _____
COMPANY ADDRESS _____ STATE _____ ZIP _____
CLAIM # _____ POLICY # _____
OTHER INFORMATION _____

DRIVER OF OTHER VEHICLE:
INSURANCE COMPANY _____ **INSURED NAME** _____
CLAIMS MANAGER _____ TELEPHONE # ( ) _____
COMPANY ADDRESS _____ STATE _____ ZIP _____
CLAIM # _____ POLICY # _____
OTHER INFORMATION _____

HAVE YOU RETAINED AN ATTORNEY? ( ) YES ( ) NO IF YES, NAME: _____
WERE THERE ANY WITNESSES? ( ) YES ( ) NO IF YES, NAME/S: _____
_____
DATE OF ACCIDENT _____ TIME OF DAY _____
WERE YOU: ( ) DRIVER ( ) PASSENGER ( ) FRONT SEAT ( ) BACK SEAT
NUMBER OF PEOPLE IN YOUR VEHICLE _____ OTHER VEHICLE _____
WHAT DIRECTION WERE YOU TRAVELING? ( ) NORTH ( ) EAST ( ) SOUTH ( ) WEST
ON (NAME OF STREET, CITY, STATE) _____
WERE YOU STRUCK FROM: ( ) BEHIND ( ) FRONT ( ) LEFT SIDE ( ) RIGHT SIDE
WERE YOU KNOCKED UNCONSCIOUS? ( ) YES ( ) NO IF YES, FOR HOW LONG? _____
WERE POLICE NOTIFIED? ( ) YES ( ) NO
IN YOUR OWN WORDS, PLEASE DESCRIBE THE ACCIDENT: _____
_____
_____

DID YOU HAVE ANY PHYSICAL COMPLAINTS <u>BEFORE</u> THE ACCIDENT? ( ) YES ( ) NO
IF YES, PLEASE DESCRIBE IN DETAIL: _____
_____
_____

PLEASE DESCRIBE HOW YOU FELT:

A. <u>DURING</u> THE ACCIDENT _____
B. <u>IMMEDIATELY AFTER</u> THE ACCIDENT _____
C. LATER THAT DAY _____
D. THE NEXT DAY _____

WHAT ARE YOUR PRESENT COMPLAINTS AND SYMPTOMS? _____

_____

_____

DO YOU HAVE ANY PREVIOUS CONGENITAL (FROM BIRTH) FACTORS WHICH RELATE TO THIS PROBLEM IN ANY WAY?
( ) YES ( ) NO IF YES, PLEASE DESCRIBE: _____

_____

_____

DO YOU HAVE ANY PREVIOUS ILLNESSES WHICH RELATE TO THIS CASE: ( ) YES ( ) NO
IF YES, PLEASE DESCRIBE: _____

_____

WHERE WERE YOU TAKEN AFTER THE ACCIDENT? _____

HAVE YOU BEEN TREATED BY AN/OTHER DOCTOR/S SINCE THIS ACCIDENT? ( ) YES ( ) NO
IF YES, PLEASE LIST THE DOCTOR/S'S NAME/S AND ADDRESS/ES: _____

_____

_____

WHAT TYPE OF TREATMENT DID YOU RECEIVE? _____

_____

SINCE THIS INJURY OCCURRED, ARE YOUR SYMPTOMS: ( ) IMPROVED ( ) WORSE ( ) SAME

HAVE YOU LOST TIME FROM WORK AS A RESULT OF THIS ACCIDENT? ( ) YES ( ) NO
IF YES, PLEASE COMPLETE THIS QUESTION:

A. LAST DAY WORKED: _____
B. TYPE OF EMPLOYMENT: _____
C. ARE YOU BEING COMPENSATED FOR TIME LOST FROM WORK? ( ) YES ( ) NO

IF YES, PLEASE STATE TYPE OF COMPENSATION YOU ARE RECEIVING, INCLUDING SALARY: _____

_____

DO YOU NOTICE ANY ACTIVITY RESTRICTIONS AS A RESULT OF THIS INJURY? ( ) YES ( ) NO
IF YES, PLEASE DESCRIBE IN DETAIL: _____

_____

_____

_____

ANY FURTHER PERTINENT INFORMATION REGARDING YOUR CASE: _____

_____

_____

HAVE YOU EVER BEEN INVOLVED IN AN ACCIDENT BEFORE: ( ) YES ( ) NO
IF YOU HAVE, PLEASE DESCRIBE, INCLUDING DATE/S AND TYPE/S OF ACCIDENTS, AS WELL AS INJURY/-IES RECEIVED:

_____

_____

_____

_____

_____ _____

DATE PATIENT'S SIGNATURE