HAYES CHIROPRACTIC CENTER

Richard Hayes D.C.
Doctor of Chiropractic

PERSONAL INJURY QUESTIONARE

YOURSELF

Name: _____Home Ph#: _____Work Ph# _____
Address: _____City: _____State: _____ Zip: _____
Age: ____Date of Birth: __/ __/ ____ Sex: ___ SS# ___/___/____ Marital Status: _____
Employers Name: _____Address: _____
Email Address: _____
1) We need a copy of your driver license. _____
2) Your Medical Insurance Company. _____
3) Your Car Insurance Company. _____
4) Other Car Insurance Company. _____

ATTORNEY

Name: _____ Ph#: _____ Fax: _____
Address: _____ City: _____ State: _____ Zip: _____

NATURE OF ACCIDENT

1. Date of Accident ___/ ___/ ____ Time of Day _____
2. Were you? Driver _____ Passenger _____ Front seat _____ Back seat _____
3. What type of vehicle were you driving? Make _____ Model _____ Year ____
4. Number of people in your vehicle ___Were you wearing seatbelts? ___Yes ____No __
5. Did your vehicle's airbag deploy? Yes ____ No_____
6. What direction was your vehicle headed? North ____South ____ East ____ West ____
7. Where was the other vehicle headed? North _____ South _____ East _____ West ____
   (Name of street) _____
8. Were you struck from? Behind ____ Front Side ____ Left Side ___ Right Side _____
9. Approximate speed of your car _____ mph, other car _____ mph.
10. Were you knocked unconscious? Yes _____ No _____
11. Was Police notified? Yes _____ No _____
12. In your own words, please describe the accident: _____
_____
_____
_____
_____
13. Did you see the accident coming _____ or was it surprise _____?
14. Was your head straight _____ or turned _____ during the accident?
15. Were there any witnesses? Yes _____ No ____ Names: _____
16. Please describe how you felt:
  a.) During the accident? _____
  b.) Immediately after the accident: _____
  c.) Later: _____
  d.) The next day: _____

17.What are your present symptoms? _____

18. Check symptoms you have noticed since the accident:
    headache ___ neck pain ___ neck stiff ___ buzzing in ear ____ ears ring ___
    dizziness ___ loss of balance ___ fainting ___ loss of memory ___ depression ___
    head seems heavy ___ irritability ___ sleeping problem ___ face flushed ___
    light bothers ___ loss of smell ___ loss of taste ___ fatigue ___ tension ___ fever __
    nervousness ___ cold sweat ___ shortness of breath ___ pins and needles in arm ___
    hands cold ___ numbness in fingers ___ stomach upset ___ diarrhea ___ feet cold __
    constipation ___ back pain ___ pins and needles in legs ___ feet cold ___
    numbness in toe ___
    Symptoms other than above: _____
19. Since the accident occurred are your symptoms:
    improving _____ getting worse _____ same_____
20. Where were you taken after this accident? _____
21. Were you taken to the hospital? Yes ____ No ____, if yes was it by ambulance____.
    Name of Hospital: _____ Date: _____
22. Have you been treated by another doctor since this accident? Yes ____ No ___, if yes please list doctor's name, address, and date. _____
23. Please list any medications prescribe from cause of accident. _____
24. Have you lost time from work as a result of this accident? Yes ___ No __, if yes please complete these questions:
    a) Last day of work? _____
    b) Describe employment: _____
    c) Are you being compensated for the time loss from work? Yes ___ No __, if yes Please state compensation you are receiving: _____
25. Did you have any congenital (from birth) factors, which related to this problem: Yes No __, if yes please describe _____
    _____
26. Did you have any previous illnesses, which relate to this accident: Yes ___ No ___, if yes please describe _____
27. Have you been involved in an accident before? Yes __ No __ if yes please describe, include date(s) and injuries that occurred: _____
    _____Injuries resolved Y N
28. Did you have any physical complaints <u>BEFORE</u> the accident? Yes ___ No ___, if yes please describe in detail and list what care was given: _____
    _____
    For doctor use only: Meds: _____, Surgeries_____
    Hx: Cancer, Diabetes, Stroke/Heart disease, HBP, Other_____
29. <u>FEMALES:</u> Could you be pregnant? ___ Yes ___ No, if you discover that you are pregnant during the course of therapy, please inform us immediately.
30. Have you had plastic surgery? ___ Yes ___ No

_____ _____

Date Patient Signature