

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 BEFORE 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. FEMALES: 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