



Burland Chiropractic

Dr. Brandi Burland
Chiropractic Physician

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PERSONAL INJURY QUESTIONNAIRE

If a Minor (under 18 years old), Name and Address of responsible parent/guardian:

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____

E-Mail Address: _____ Social Security #: _____

Date of Birth: _____ Age: _____ Sex: M F Status: Married Single Other _____

Referred to this office by: _____

Name of Emergency Contact: _____ Relationship: _____

Home Phone: _____ Cell: _____ Work: _____

Employer: _____ Occupation/Title: _____

Have you been able to work since the accident: Yes No Are you being compensated: Yes No

Auto Insurance Company: _____

Insurance Co. Phone #: _____ Claim #: _____

Representative's Name: _____

Attorney Name: _____ Attorney Phone #: _____

Date of Accident: _____ Time of Day: _____

Were You: Driver Passenger Front Seat Back Seat Number of people in your vehicle: _____

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

Were you taken to the hospital after THIS accident: Yes No

Were you wearing a seatbelt: Yes No

Did the airbags deploy: Yes No

If you are female, are you pregnant: Yes No

In your own words, please describe the accident and how you felt during/after: _____

Have you ever been involved in an accident before: No Yes, Describe: _____

Did you have any physical complaints BEFORE THE ACCIDENT: No Yes, Describe: _____

What are your PRESENT complaints and symptoms: _____

Have you been treated by another doctor since the accident: No Yes, Who: _____

Do you have a primary care physician: No Yes, Who: _____

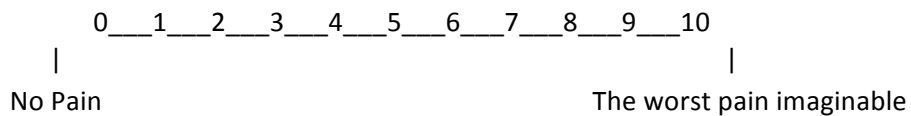
Since this injury occurred, are your symptoms: Improving Getting Worse Same

CIRCLE THE SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT:

- | | | |
|---------------------|---------------------|----------------------------|
| NECK PAIN | NUMBNESS-LEGS/TOES | BOWEL OR BLADDER CHANGES |
| MID BACK PAIN | NUMBNESS-ARMS/HANDS | SLEEPING PROBLEMS |
| LOW BACK PAIN | DIZZINESS | DEPRESSION |
| HEADACHE | LOSS OF BALANCE | |
| TINGLING-ARMS/HANDS | LOSS OF MEMORY | Symptoms other than above: |

Other pertinent information:

Please rate your level of discomfort at the moment:



Please use the diagram to describe your symptoms and mark the exact location:

