Burland Chiropractic

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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

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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:

0___1___2___3___4___5___6___7___8___9___10

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No Pain The worst pain imaginable

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