PERSONAL INJURY QUESTIONNAIRE
FOR KORWITTS CHIROPRACTIC CENTER

Name: ________________________________ Phone: ____________________

Street Address: ____

City: ______________________ State: ______ Zip Code: _______________

Age: ______ Birthdate: ____________ Sex: ______ S/S#: _______________

Employer's Name: ____________________ ____________________________

Employer's Address: ____

Your Ins. Co.: ____

Policy #: ________________ Agent's Name: ____________________________

Responsible Party's Name: ____

Address: ____

City: ______________________ State: ______ Zip Code: _______________

Policy Holder's Name: _______________________ Policy #: _______________

ATTORNEY

Name: ________________________________ Phone: ____________________

Address: ____

City: ______________________ State: ______ Zip Code: _______________

Were there any witnesses?: ___ Yes / ___ No Name(s): _________________________

NATURE OF ACCIDENT:

1. Date of Accident: ____________________ Time of Day: _________________________

2. Were you: ___ Driver ___Passenger ___Front Seat ___Back Seat

3. Number of people in your vehicle: _________ Were you wearing seat belts? ___________________

4. What direction were you headed?: ___North ___East ___South ___West

   on (name of street): ____

5. What direction was other vehicle headed?: ___North ___East ___South ___West

   on (name of street): ____

6. Were you struck from: ___Behind ___Front ___Left side ___Right side

7. Approximate speed of your vehicle: _____mph Other vehicle: _____mph

8. Were you knocked unconscious?: ___ Yes / ___ No If yes, for how long?: _________

9. Was the police notified?: ___ Yes / ___ No

10. In your own words, please describe accident: ____

____

____

____

11. Did you have any physical complaints BEFORE the accident?: ___ Yes / ___ No

    If yes, please describe in detail: ____

____

____

____

12. Please describe how you felt:

a. DURING the accident: ____

____

b. IMMEDIATELY AFTER the accident: ____

____

c. LATER THAT DAY: ____

____

d. THE NEXT DAY: ____

____

13. What are your PRESENT complaints and symptoms?: _________________________________

____

____

14. Do you have any congenital (from birth) factors which relate to this problem?: ___ Yes / ___ No

If yes, please describe: ____

15. Do you have any previous illnesses which relate to this case?: ___ Yes / ___ No

If yes, please describe: ____

16. Have you ever been involved in an accident before?: ___ Yes / ___ No

If yes, please describe, including date(s) and type(s) of accidents, as well as injury/injuries received: ____

____

____

17. Where were you taken after the accident?: ____

____

18. Have you been treated by another doctor since the accident?: ___ Yes / ___ No

If yes, please list doctor's name and address: ____

____

What type of treatment did you receive?: ____

____

19. Since this injury occurred, are your symptoms: ___ Improving ___ Getting worse ___ Same

20. Check symptoms you have noticed since accident:

☐ Headache	☐ Irritability	☐ Numbness in Toes	☐ Face Flushed	☐ Feet Cold
☐ Neck Pain	☐ Chest Pain	☐ Shortness of Breath	☐ Buzzing in Ears	☐ Hands Cold
☐ Neck Stiff	☐ Dizziness	☐ Fatigue	☐ Loss of Balance	☐ Stomach Upset
☐ Sleeping Problems	☐ Head Seems Too Heavy	☐ Depression	☐ Fainting	☐ Constipation
☐ Back Pain	☐ Pins & Needles in Arms	☐ Lights Bother Eyes	☐ Loss of Smell	☐ Cold Sweats
☐ Nervousness	☐ Pins & Needles in Legs	☐ Loss of Memory	☐ Loss of Taste	☐ Fever
☐ Tension	☐ Numbness in Fingers	☐ Ears Ring	☐ Diarrhea	☐ ___________

Symptoms other than above: ____

21. 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. Present Salary: ____
d. Are you being compensated for time lost from work?: ___ Yes / ___ No

    If yes, please state type of compensation you are receiving:

    ____

22. Do you notice any activity restrictions as a result of this injury?: ___ Yes / ___ No

If yes, please describe, in detail: ____

____

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23. Other pertinent information: ____

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