Gilden
Family Chiropractic

PERSONAL INJURY QUESTIONNAIRE

Last Name_____

First Name _____

Phone

(Home)_____

(Cell)_____

(Work)_____

Address

Street_____

City_____ State_____ Zip_____

SS#_____

Date of Birth_____

DL#_____

INSURANCE INFORMATION

Last Name _____

First Name_____

YOUR AUTO INSURANCE INFORMATION:

Name of Insured _____ Policy # _____
Insurance Company _____ Phone # _____
Address _____ City _____ Zip _____
Amount of "Medical Payment" _____ Adjuster _____

THE AUTO INSURANCE OF THE OTHER PARTY INVOLVED:

Name of Insured _____ Policy # _____
Insurance Company _____ Phone # _____
Address _____ City _____ Zip _____
Adjuster _____ Claim # _____

ATTORNEY INFORMATION (IF APPLICABLE):

Attorney Name _____ Phone # _____
Address _____ City _____ Zip _____

LIABILITY INFORMATION:

Who's fault do you believe the accident was: _____
Is the other drivers insurance company accepting liability? ( ) Yes ( ) No
(The other drivers insurance company will send you a letter lettering you know if the are accepting liability)

ACCIDENT INFORMATION:

Date of Accident _____ Time of Day _____ am/pm

What best describes what happened in your accident:
( ) Your car was hit by another car. ( ) Your car hit another car. ( ) Your car was the only car involved.
( ) Your car was hit by another car and it pushed you into a third car. ( ) Other: _____

_____

Were you: ( ) Driver ( ) Passenger ( ) Front Seat ( ) Back Seat

Were any of the drivers including yourself charged with a DUI? ( ) Yes ( ) No
If Yes who: _____

Did the air bag in your car deploy? ( ) Yes ( ) No
Did you have a seatbelt on? ( ) Yes ( ) No
How fast was your car moving? _____ How fast was the other car moving? _____
What type of car were you driving? _____
What type of car was the other car? _____

Was the impact to your car: ( ) Front ( ) Side ( ) Rear ( ) Other _____
Was the impact to the other car: ( ) Front ( ) Side ( ) Rear ( ) Other _____

Did you go in an ( )Ambulance or go to the ( )ER: What ER:_____
How many passengers were in the car with you? ____ What where there injuries:_____
Did anyone involved in the accident need an ( ) Ambulance or go to the ( ) ER. Who:_____

What was the damage to the vehicles involved _____
What is the estimate to fix your car $_____

Use one or both of the diagrams below to show what happened during your accident.

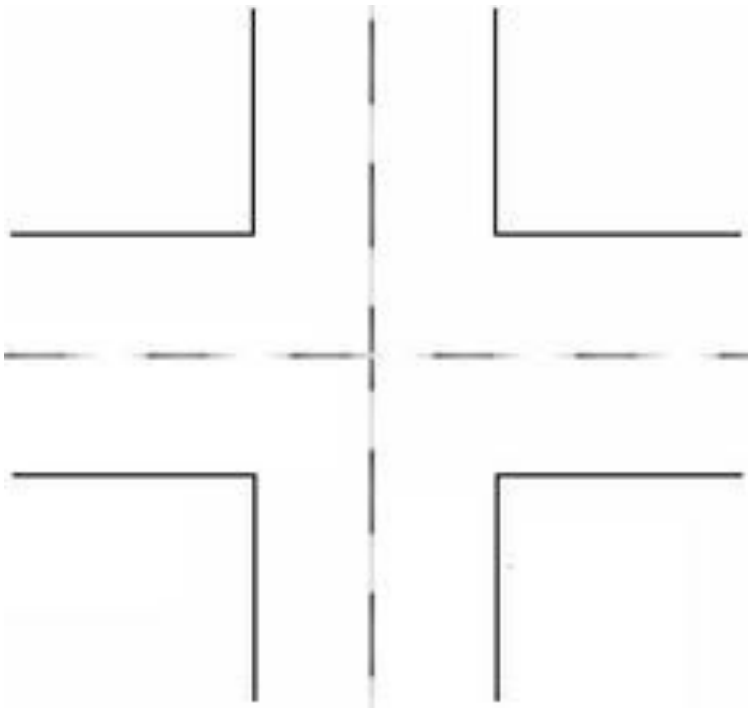
Your Car: 0

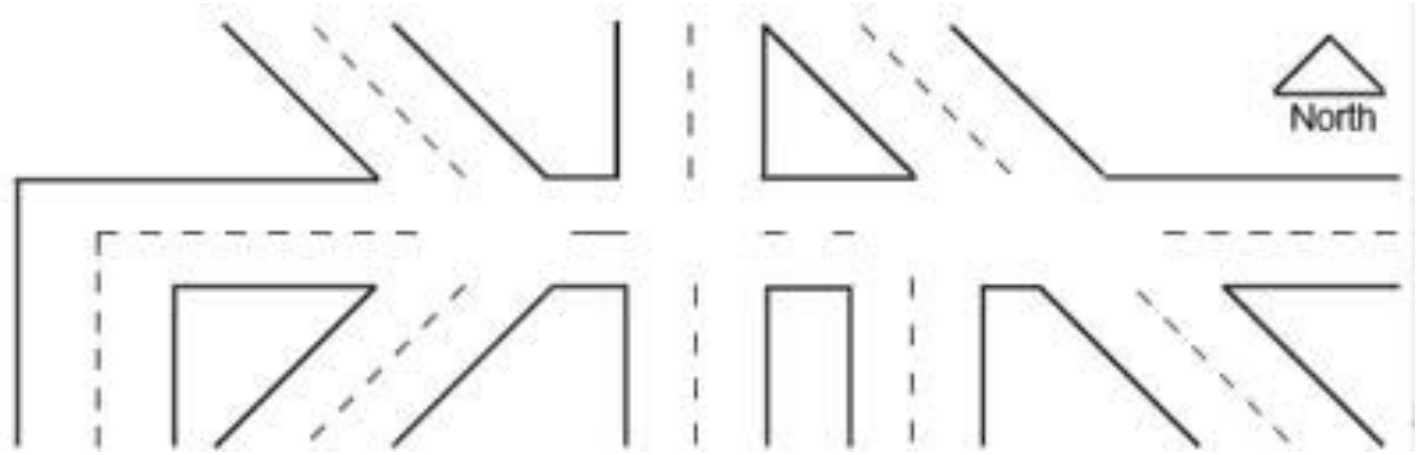
Other Cars: X

Stop Sign:

Stop Light:

Direction: →





Explain in your own words what happened during the accident: _____

_____

_____

_____

_____

_____

_____

_____

THE FOLLOWING PAGES ARE VERY IMPORTANT TO FILL OUT COMPLETLY:

When did you first notice any symptoms _____

Since the car accident, have your symptoms:
( ) improved ( ) stayed the same ( ) gotten worse

Did you receive any other medical/chiropractic care directly after the accident: ( ) Yes ( ) No
If yes, please describe: _____
_____
_____

Have you lost any time from work as a result of the accident? ( ) Yes ( ) No
If yes, please describe: _____
_____
_____

The Following question is important to answer as accurately as possible. Past accidents are very important to document correctly since they can explain why even a small accident can cause your body to have major damage. The insurance company will not reject your claim based on past accidents.

Did you have any physical complaints before the accident? ( ) Yes ( ) No
If yes, please describe: _____

_____

_____

_____

_____

Other pertinent information: _____
_____

_____

_____

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Initial Evaluation

Restrictions of Daily Activates

Name:_____ Date:_____/_____/_____

It is very important to document the restrictions you have in your daily life since the accident. Please fill out any of the following activates that you are experiencing difficulty and add any additional activates that are not listed in the blanks below.

Activities And Body Movements	Performance Level 0 to 10 0= Unable To Do 10=No Restriction	Pain Level 0 to 10 0=No Pain 10=Intense Pain	Additional Comments
Driving			
Exercising			
Walking			
Working			
Sleeping			
Sitting			
Standing			
Shaving			
Neck Bending			
Neck Rotation			
Mid Back Bending			
Mid Back Rotation			
Low Back Bending			
Low Back Rotation			

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Initial Evaluation

Head Trauma/Pain List

Name:_____ Date:_____/_____/_____

General Location/Item	Specific Location/Item	Pain Level 0=No Pain 10=Intense	Describe The Pain/Item	Duration Of Pain/Item	Time Of Day
Headache					
Dizziness					
Nausea					
Vertigo					
Ringing In Ears					
Loss Of Hearing					
Ear Discharge					
Loss Of Eye Sight					
Seeing Things					
Pain Around eyes					
Light Sensitive					
Loss Of Smell					
Nasal Discharge					
Nose Pain					
Face Flushed					
Face Pain					
Memory Loss					
Balance Loss					
Fainting					
Fatigue					
Depression					
Confusion					
Irritable					
Difficulty Talking					
Change Of Taste					
Sleep Disturbances					

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Initial Evaluation

Body Trauma/Pain List

Name:_____ Date:_____/_____/_____

General Location	Specific Location	Pain Level 0=No Pain 10=Intense	Describe The Pain (Sharp, Dull)	Duration Of The Pain	Time Of Day
Upper Neck					
Lower neck					
Upper Back					
Middle Back					
Lower Back					
Lt. Hip					
Rt. Hip					
Lt. Shoulder					
Rt. Shoulder					
Lt. Arm					
Rt. Arm					
Lt. Hand					
Rt. Hand					
Lt. Thigh					
Rt. Thigh					
Lt. leg					
Rt. Leg					
Lt. Foot					
Rt. Foot					
Radiating Pain					

Signed _____ **Date** _____

Legal Guardian (if applicable) _____ **Date** _____