

CENTER FOR HEALTH
DR. GARY J. POST, CHIROPRACTIC PHYSICIAN
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AUTO ACCIDENT/PERSONAL INJURY QUESTIONNAIRE

Name: _____ Today's Date: _____
Address: _____
Phone: Home: _____ Cell: _____ Work: _____ Email: _____
Social Security #: _____ Sex: M F Date of Birth: _____ Marital Status: _____
Occupation: _____

Date and Time of Accident _____ AM PM

Did the police come to the accident site? Yes No
Was a police report filed? Yes No
Were there any witnesses? Yes No

What was your position in the car?
Driver: If Driver were your hands on the steering wheel? Left Right Both
Passenger: If passenger, were you sitting in Front Right Rear Left Rear

Did you brace for impact? Yes No I braced with my hands I braced with my feet
Which way were you facing at the time of impact? Straight ahead Left Right
Did your vehicle strike another vehicle? Yes No Was your vehicle struck by another vehicle Yes No
Number of people in the accident vehicle? _____
Were you wearing a seat belt? Yes No
Was this vehicle equipped with air bags? Yes No
If yes, did it/they inflate? Yes No
In relation to the base of your skull where was the headrest? Above Below At base of skull
What did your vehicle impact? Another vehicle Other _____
Did you strike anything in vehicle at time of impact? Yes No
If yes, specify what part of your body struck what? _____
Did the seat back bend / break? Yes No

Where did accident happen? Describe the accident in your own words:

Make and model of vehicle you were occupying? _____
Make and model of other vehicle? _____
Name and location of street you were traveling? _____
What direction were you headed? N S E W
What was the approximate speed of your vehicle? _____ What was approximate speed of other vehicle? _____
Did the impact to your vehicle come from the Front Rear Right Side Left Side Other _____
During impact were you facing Right Left Forward

Immediately following the accident, how did you feel? dizzy/dazed disoriented unconscious-how long? _____
nervous nauseous upset weak Other _____

Did you go to hospital Yes No Were you admitted to the hospital? Yes No If yes, how long? _____

If you went to hospital, when? At time of accident Next day Two days plus

How did you get to hospital? Ambulance Police Car Private Transportation

Name of Hospital: _____

Attended by Dr. _____

If so, what treatment was given? _____

Have you seen any other doctor as a result of this accident? Yes No If yes, when? _____

Doctor's name: _____

Chief Complaints or Symptoms as a result of this accident. Mark all that apply.

<input type="checkbox"/> Neck pain	<input type="checkbox"/> none	<input type="checkbox"/> left shoulder	<input type="checkbox"/> left arm	<input type="checkbox"/> left forearm	<input type="checkbox"/> left hand
If it radiates, mark where it goes	<input type="checkbox"/> right shoulder	<input type="checkbox"/> right arm	<input type="checkbox"/> right forearm	<input type="checkbox"/> right hand	
<input type="checkbox"/> Jaw Pain	<input type="checkbox"/> Rt <input type="checkbox"/> Lt	<input type="checkbox"/> Headache	<input type="checkbox"/> Blurry Vision	<input type="checkbox"/> Ringing in Ears	
<input type="checkbox"/> Shoulder Pain	<input type="checkbox"/> Rt <input type="checkbox"/> Lt	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Nervousness	<input type="checkbox"/> Loss of Concentration	
<input type="checkbox"/> Chest Pain		<input type="checkbox"/> Fatigue	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Depression	
<input type="checkbox"/> Upper back pain	<input type="checkbox"/> Rt <input type="checkbox"/> Lt	<input type="checkbox"/> Difficulty with sleeping at night	<input type="checkbox"/> Fear of driving in a car		

<input type="checkbox"/> Low Back Pain	<input type="checkbox"/> none	<input type="checkbox"/> buttocks	<input type="checkbox"/> left buttock	<input type="checkbox"/> left thigh	<input type="checkbox"/> left knee
select the areas of radiation, if any...	<input type="checkbox"/> left foot	<input type="checkbox"/> right buttock	<input type="checkbox"/> right thigh	<input type="checkbox"/> right knee	<input type="checkbox"/> right foot

Hip Pain	<input type="checkbox"/> Left	<input type="checkbox"/> Right	<input type="checkbox"/> Bilateral
Knee Pain	<input type="checkbox"/> Left	<input type="checkbox"/> Right	<input type="checkbox"/> Bilateral
Foot Pain	<input type="checkbox"/> Left	<input type="checkbox"/> Right	<input type="checkbox"/> Bilateral

Additional Symptoms/ Complaints:

Is your condition getting worse? Yes No Constant Comes and goes

Indicate your degree of comfort while performing the following activities:

	Comfortable	Uncomfortable	Painful		Comfortable	Uncomfortable	Painful
Standing				Walking			
Sitting				Running			
Lying Down				Working			
Lovemaking				Lifting/Bending			

Have you lost any time from work due to your injuries? No Yes, give dates: _____

Type of employment: _____

How many hours are in your normal workday? _____

Please indicate your daily job duties and any activities you are occasionally asked to perform.

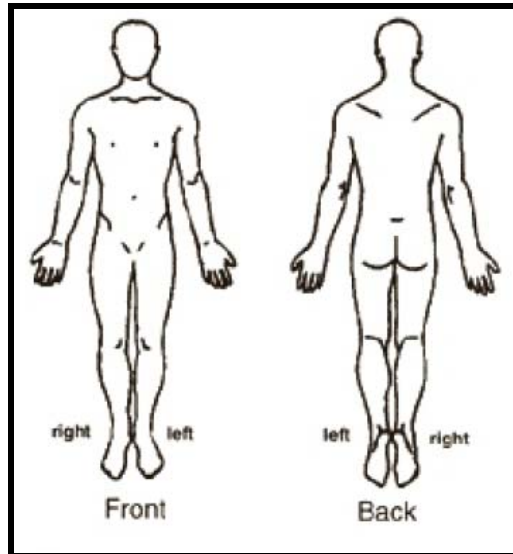
- Standing Driving Operating Equipment Bending Stooping Work with arms above head
 Sitting Twisting Walking Crawling Typing Lifting Other _____

Prior to the accident were you capable of working on an equal basis with others? Yes No N/A

While in recovery is there any light duty work you can request? Yes No N/A

Have you retained an attorney? Yes No If yes, whom? _____

Please mark on the pictogram with an X the site(s) where your pain is.



Overall Pain Scale

Please circle the number that best describes your pain. If multiple areas, please put numbers on the above chart.

- 0 1 2 3 4 5 6 7 8 9 10**
NONE LITTLE MEDIUM SEVERE

Please Sign: _____

Date: _____