



**HAMPTON BAYS**  
**CHIROPRACTIC & NUTRITION**

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**Personal Injury Questionnaire**

Name \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Age \_\_\_\_\_ Birth Date \_\_\_\_\_ Sex \_\_\_\_\_ Last 4 of SS# \_\_\_\_\_

Insurance Company Name \_\_\_\_\_ Claim # \_\_\_\_\_

Adjusters Name \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Name on Policy (If other than self) \_\_\_\_\_ Their Birth Date \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Do you have an Attorney representing you? ( ) Yes ( ) No

Attorney Name \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**NATURE OF ACCIDENT**

1. Date of Accident \_\_\_\_\_ Time of Day \_\_\_\_\_

2. Were you: ( ) Diver ( ) Passenger ( ) Front Seat ( ) Back Seat

3. Number of people in the vehicle? \_\_\_\_\_ Were you wearing seat belts? ( ) Yes ( ) No

4. What direction were you headed? ( ) North ( ) South ( ) East ( ) West  
Name of street and town \_\_\_\_\_

5. What direction was the other vehicle headed? ( ) North ( ) South ( ) East ( ) West  
Name of street and town \_\_\_\_\_

6. Were you struck from: ( ) Behind ( ) Front ( ) Left Side ( ) Right Side

7. The approximate speed of your car \_\_\_\_\_ mph The other car \_\_\_\_\_ mph

8. Were you knocked unconscious? ( ) Yes ( ) No If yes, for how long? \_\_\_\_\_

9. Were the police notified? ( ) Yes ( ) No Were there any witnesses? ( ) Yes ( ) No

10. In your own words, please describe the accident:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

11. Did you have any physical complaints BEFORE THE ACCIDENT? ( ) Yes ( ) No If yes, please describe:  
\_\_\_\_\_  
\_\_\_\_\_

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 & 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. Include date(s),  
type(s) of accident(s), as well as injury(ies) sustained. \_\_\_\_\_  
\_\_\_\_\_

17. Did you go to the Hospital/Urgent Care? ( ) Yes ( ) No If yes, where? \_\_\_\_\_

18. Have you been treated by another doctor since the accident? ( ) Yes ( ) No If yes, please list doctor's name  
& address: \_\_\_\_\_

What type of treatment did you receive? \_\_\_\_\_

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

20. Check any symptoms you have notices since the accident:

- |  |   |   |  |  |
|--|---|---|--|--|
| <input type="checkbox"/> Headache          | <input type="checkbox"/> Irritability   | <input type="checkbox"/> Numbness in toes       | <input type="checkbox"/> Face flushed    | <input type="checkbox"/> Feet cold     |
| <input type="checkbox"/> Neck Pain         | <input type="checkbox"/> Chest pain     | <input type="checkbox"/> Shortness of breath    | <input type="checkbox"/> Buzzing in ears | <input type="checkbox"/> Hands cold    |
| <input type="checkbox"/> Neck stiff        | <input type="checkbox"/> Dizziness      | <input type="checkbox"/> Head seems too heavy   | <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Stomach upset |
| <input type="checkbox"/> Sleeping problems | <input type="checkbox"/> Fatigue        | <input type="checkbox"/> Pins & Needles in Arms | <input type="checkbox"/> Fainting        | <input type="checkbox"/> Constipation  |
| <input type="checkbox"/> Back pain         | <input type="checkbox"/> Depression     | <input type="checkbox"/> Pins & Needles in Legs | <input type="checkbox"/> Loss of smell   | <input type="checkbox"/> Cold sweats   |
| <input type="checkbox"/> Nervousness       | <input type="checkbox"/> Loss of memory | <input type="checkbox"/> Lights bother eyes     | <input type="checkbox"/> Loss of taste   | <input type="checkbox"/> Fever         |
| <input type="checkbox"/> Tension           | <input type="checkbox"/> Ears Ring      | <input type="checkbox"/> Numbness in fingers    | <input type="checkbox"/> Diarrhea        |  |

Any other symptoms that are not listed? \_\_\_\_\_

21. Have you lost time from work as a result of this accident? ( ) Yes ( ) No If yes, please answer a-d below.

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 what 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:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

23. Other pertinent information:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date