PERSONAL INJURY QUESTIONNAIRE

PLEASE ANSWER ALL QUESTIONS COMPLETELY

Date: _____

Patient: _____ Date of Birth:_____

Sex: _____ Marital Status: _____ Social Security No.:_____

Cell Phone: _____ Home Phone:_____ Work Phone:_____

Employer: _____ Address: _____

Name of Spouse/Guardian: _____ Phone Number:_____

Where did the injury occur? _____

_____

Please explain in detail how your injury occurred? _____

_____

_____

_____

Give time and date present injury occurred _____ ❑ AM ❑ PM _____/_____/_____

When did your symptoms begin? ❑ Immediately ❑ Later that day ❑ Next day ❑ _____

Where did you feel pain/symptoms after the accident? _____

_____

Did you receive treatment immediately after the accident? _____

_____

Did you consult any other doctor for this injury? ❑ Yes ❑ No

If so, give Doctors name: _____ ❑ D.C. ❑ M.D. ❑ D.O. ❑ D.D.S

Doctor's Diagnosis: _____

What treatment was given? _____

How often did you see the Doctor? _____

Have you ever had any complaints in the involved area before? ❑ Yes ❑ No Date: _____

If so, what were the complaints? _____

Before the injury were you capable of working on an equal basis with others your age? ❑ Yes ❑ No

Are your work activities restricted as a result of this accident? ❑ Yes ❑ No

Since the injury, are your symptoms ❑ improving? ❑ getting worse? ❑ staying the same?

Have you retained an attorney? ❑ Yes ❑ No Litigation? ❑ Yes ❑ No

If so, name, address and phone #? _____

Are your claims being filed through your medical insurance? ❑ Yes ❑ No

HEALTH QUESTIONNAIRE

PLEASE CHECK MARK EACH OF THE CONDITIONS BELOW THAT YOU ARE CURRENTLY EXPERIENCING

Patient: _____ Date: _____ No: _____

MUSCULOSKELETAL SYSTEM

- ❑ Low back pain
- ❑ Mid back pain
- ❑ Pain between shoulders
- ❑ Neck pain
- ❑ Arm problems
- ❑ Leg problems
- ❑ Swollen joints
- ❑ Painful joints
- ❑ Stiff joints
- ❑ Sore muscles
- ❑ Weak muscles
- ❑ Walking problems
- ❑ Spasms
- ❑ Broken bones
- ❑ Shoulder problems

GENITO-URINARY SYSTEM

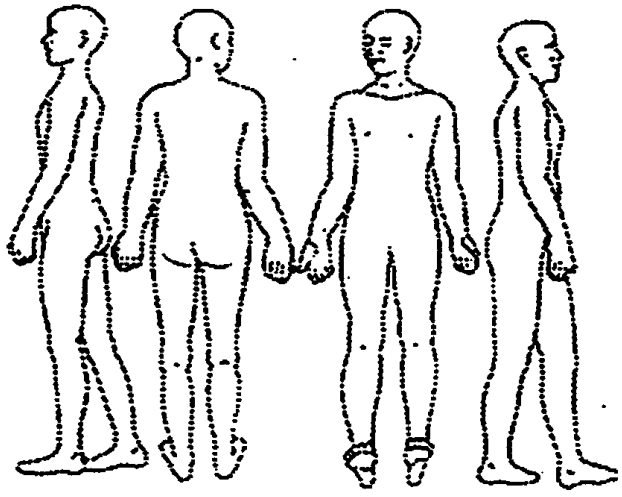
- ❑ Bladder trouble
- ❑ Excessive urination
- ❑ Scanty urination
- ❑ Painful urination
- ❑ Discolored urine

FEMALE

- ❑ Vaginal discharge
- ❑ Vaginal bleeding
- ❑ Vaginal pain
- ❑ Breast pain
- ❑ Lumps on the breast

ARE YOU PREGNANT?
❑ **YES** ❑ **NO**

SYMPTOM LOCALIZATION



P ___ Pain
N ___ Numb
S ___ Spasm

T ___ Tender
H ___ Hypoesthesia
(decrease of sensitivity)

Pain Index

Least 1 2 3 4 5 6 7 8 9 10 Worst

GASTRO-INTESTINAL SYSTEM

- ❑ Poor appetite
- ❑ Excessive hunger
- ❑ Difficulty chewing
- ❑ Difficulty swallowing
- ❑ Excessive thirst
- ❑ Nausea
- ❑ Vomiting blood
- ❑ Abdominal pain
- ❑ Diarrhea
- ❑ Constipation
- ❑ Black stool
- ❑ Bloody stool
- ❑ Hemorrhoids
- ❑ Liver trouble
- ❑ Gall bladder problems
- ❑ Weight trouble

NERVOUS SYSTEM

- ❑ Numbness
- ❑ Loss of Feeling
- ❑ Paralysis
- ❑ Dizziness
- ❑ Fainting
- ❑ Headaches
- ❑ Muscle Jerking
- ❑ Convulsions
- ❑ Forgetfulness
- ❑ Confusion
- ❑ Depression
- ❑ Insomnia

HABITS

- ❑ Smoking
- ❑ Alcohol use
- ❑ Coffee or tea:
- ❑ Drug abuse
- ❑ _____

CARDIO-VASCULAR RESPIRATORY

- ❑ Chest pain
- ❑ Pain over heart
- ❑ Difficulty breathing
- ❑ Persistent cough
- ❑ Coughing phlegm
- ❑ Coughing blood
- ❑ Rapid heartbeat
- ❑ Blood pressure problems
- ❑ Heart problems
- ❑ Lung problems
- ❑ Varicose veins

EYE, EAR, NOSE & THROAT

- ❑ Eye strain
- ❑ Eye inflammation
- ❑ Vision problems
- ❑ Ear pain
- ❑ Ear noises
- ❑ Ear discharge
- ❑ Hearing loss
- ❑ Nose pain
- ❑ Nose bleeding
- ❑ Nose discharge
- ❑ Difficulty breathing through nose
- ❑ Sore gums
- ❑ Dental problems
- ❑ Sore mouth
- ❑ Sore throat
- ❑ Hoarseness
- ❑ Difficulty with speech
- ❑ Sinus
- ❑ Allergy
- ❑ Jaw pain

Patient Signature: _____