

**Chiropractic Central**

1935 NE 39<sup>th</sup> Ave.

Portland, OR 97212

**PERSONAL INJURY QUESTIONNAIRE**

Name \_\_\_\_\_

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**Details of the Accident ( Please circle appropriate responses ) :**

1. Date of Accident \_\_\_\_\_ Time of Day \_\_\_\_\_ AM/ PM
2. Road Conditions: Dry Wet Icy Gravel Road Pavement Other
3. Were you: Driver Passenger Front Seat Back Seat
4. What direction were you headed? North South East West  
On ( Name of street ) \_\_\_\_\_
5. Were you struck from: Front Rear Left Side Right Side
6. Were you aware of the impending collision? Yes No
7. Did you lose consciousness (black out) ? Yes No  
If yes, for approximately how long were you unconscious? \_\_\_\_\_
8. Were you wearing a seatbelt at the time? Yes No  
What type of belt? Lap Belt Shoulder Belt Shoulder & Lap Belt
9. Describe the position of you head rest or seat back relative to the  
back of your head: # Inches away from: \_\_\_\_\_
10. List the year, make and model of vehicle you were in:  
Year \_\_\_\_\_ Make \_\_\_\_\_ Model \_\_\_\_\_
11. Was the vehicle you were in at the time of impact: Stopped/ Moving  
If stopped was driver's foot on the brake? Yes No
12. In your own words, please describe the accident:
  
  
  
  
  
  
  
  
  
  
13. Were the police notified of the accident? Yes No
14. Please describe what happened to you following the accident ( i.e. transported  
to hospital by ambulance, taken to hospital by friend, etc.) :
  
  
  
  
  
  
  
  
  
  
15. Please describe bleeding cuts of bruises received as a result of your accident:
  
  
  
  
  
  
  
  
  
  
16. Please describe if any of your body parts struck any part of the vehicle.  
For example, head hit windshield, chest hit steering wheel, etc.:

17. Was your head pointed straight ahead at the time of the accident? Yes No  
If "no", which direction was it turned and by how much?
18. Was your torso pointed straight ahead at the time of the accident? Yes No  
If "no", which direction was it turned and by how much?
19. Which of the following vehicle parts broke during the accident:  
Windshield Rt. / Lt Window Front / Back Seat Steering Wheel  
Other \_\_\_\_\_
20. What was the cost of damage to the vehicle you were in?

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**The following questions pertain to the other vehicle involved in the accident:**

1. What was the year, make and model of the other vehicle:  
Year \_\_\_\_\_ Make \_\_\_\_\_ Model \_\_\_\_\_
2. Was the other vehicle moving at the time of the collision? Yes No
3. If the other vehicle was moving at the time of the accident, was it:  
slowing down gaining speed traveling at a steady speed

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**Health History Questions**

1. What are your complaints or symptoms (since the accident) :
2. Did you have any physical complaints BEFORE THE ACCIDENT? Yes/ No  
If yes, please describe in detail:
3. Have you received treatment for this injury since the accident?  
If yes, please list the doctor's name and address and describe the type of treatment received:
4. If you have been in previous auto accidents or have received treatment for any other significant injuries other than described above, please list the type of accident or injury and the approximate date below:

To the best of my knowledge, the information provided above is true and correct.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

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 1935 NE 39<sup>th</sup> Ave.  
 Portland, OR 97212  
**SYMPTOMS AND INJURIES**

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Check those that apply:

- |  |           |          |           |          |
|--|-----------|----------|-----------|----------|
| Concussion?  | Yes _____ | No _____ |           |          |
| Headaches?   | Yes _____ | No _____ |           |          |
| Dizziness?   | Yes _____ | No _____ |           |          |
| Nausea?  | Yes _____ | No _____ |           |          |
| Loss of Balance?   | Yes _____ | No _____ |           |          |
| ringing in ears?   | Yes _____ | No _____ |           |          |
| Blurred vision?  | Yes _____ | No _____ |           |          |
| Loss of memory?  | Yes _____ | No _____ |           |          |
| Fluid in ears?   | Yes _____ | No _____ |           |          |
| Vomiting?  | Yes _____ | No _____ |           |          |
| Jaw pain?  | Yes _____ | No _____ |           |          |
| Clicking in jaw?   | Yes _____ | No _____ |           |          |
| Eating/ chewing difficulty?                                  | Yes _____ | No _____ |           |          |
| Neck pain?   | Yes _____ | No _____ |           |          |
| Shoulder pain?   | Yes _____ | No _____ |           |          |
| Back pain?   | Yes _____ | No _____ |           |          |
| Hip pain?  | Yes _____ | No _____ |           |          |
| Numbness or tingling in the arms/ hands/ fingers ( R or L )? |           |          | Yes _____ | No _____ |
| Numbness or tingling in the legs and or feet ( R or L )?     |           |          | Yes _____ | No _____ |

**IMPAIRED ACTIVITIES (Circle those that apply)**

- |               |                     |             |                |           |
|---------------|---------------------|-------------|----------------|-----------|
| <b>SPORTS</b> | aerobic exercise    | archery     | backpacking    | bowling   |
| badminton     | baseball            | basketball  | basketry       | bicycling |
| boxing        | card playing        | camping     | dancing        | fencing   |
| fishing       | flying              | football    | gardening      | golf      |
| handball      | gymnastics          | healthclubs | hockey         | hunting   |
| judo          | horseback riding    | ice skating | karate         | painting  |
| pottery       | jogging/ running    | photography | raquetball     | rafting   |
| yoga          | mountain climbing   | snow skiing | sailing        | tennis    |
| soccer        | rowing/ boating     | softball    | water skiing   | swimming  |
| walking       | musical instruments | volleyball  | weight lifting |           |

**DAY TO DAY ACTIVITIES**

- |           |                    |           |                |             |
|-----------|--------------------|-----------|----------------|-------------|
| Dressing  | bathing/ showering | bending   | brushing teeth | cooking     |
| Holidays  | Dining out         | ironing   | housecleaning  | movie going |
| laundry   | sexual relations   | lifting   | church events  | eating      |
| moving    | shampooing hair    | reading   | shaving        | shopping    |
| sitting   | watching TV        | sleeping  | social events  | standing    |
| traveling | car washing        | vacations | yard work      | child care  |

**WORK-RELATED ACTIVITIES**

- |         |          |             |               |         |
|---------|----------|-------------|---------------|---------|
| sitting | standing | telephoning | computer work | lifting |
| reading | bending  | typing      | writing       |         |