Wise Chiropractic, LLC 522 NW 12th Ave, Portland, OR 97209

PERSONAL INJURY QUESTIONNAIRE

NAME: _____ Date of Accident_____

How and where did the accident happen? Describe in your own words:
_____
_____
_____

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 your vehicle strike another vehicle: □ Yes □ No **Was your vehicle struck by another vehicle** □ Yes □ No
Angles of impact… First Collision: □ Front □ Back □ Left □ Right **If Second Collision**: □ Front □ Back □ Left □ Right
Were you wearing a seat belt? □ Yes □ **No** **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 you strike anything in vehicle at time of impact? □ Yes □ No **If yes, specify what part of your body struck what**: ie… *head chest chin shoulder Right / Left Knee*
□ Steering Wheel _____ □ Dashboard _____

□ Windshield _____ □ Roof_____

□ Left Side Door _____ □ Right Side Door_____

□ Left Side Window. _____ □ Right Window _____

Other _____

Did the seat back bend / break? Yes No **Immediately following the accident, how did you feel?** dizzy/dazed disoriented unconscious 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 **How did you get to hospital**? □ Ambulance
□ Police Car □ Private Transportation **Name of Hospital**:_____
Attended by Dr. _____
… what treatment was given? □ none □ placed in a cervical collar □ x-rayed □ given stitches □ Bandaged □ given pain medication □ given instructions regarding concussions □ given instructions regarding sprains and strains □ Physical Therapy □ instructed to call a Orthopedic Surgeon □ instructed to call a private physician □ referred to this office for treatment □ Other _____

Have you seen any other doctor as a result of this accident? □Yes □ No Doctor's name : _____

If so, what treatment was given? _____

CHIEF COMPLAINTS & SYMPTOMS

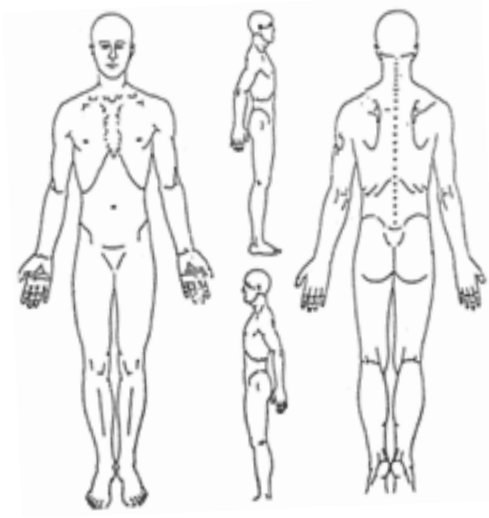
□ **Neck pain** (*check off the areas that the pain runs into from the neck* …) □ none □ left shoulder □ left arm
□ left forearm □ left hand □ right shoulder □ right arm □ right forearm □ right hand

□ **Headache** □ Migraine Headache □ Tension Headache □ Upper Back pain □ Chest or Rib Pain

□ **Ringing in Ears** □ Left □ Right □ Both
□ **Wrist Pain** □ Left □ Right □ Both
□ **Jaw Pain** □ Left □ Right □ Both

□ **Blurry Vision** □ Left □ Right □ Both
□ **Elbow Pain** □ Left □ Right □ Both

Mark all areas of symptoms



□ **Low Back Pain** (*select the areas of radiation, if any…*) □ none
□ both buttocks □ left buttock □ right buttock
□ left thigh □ left knee □ left foot □ right buttock
□ right thigh □ right knee □ right foot

Hip Pain □ Left □ Right □ Bilateral
Knee Pain □ Left □ Right □ Bilateral
Foot Pain □ Left □ Right □ Bilateral

Numbness/Tingling/Parasthesia:
□ Left Hand □ Left Upper Arm
□ Right Hand □ Right Upper Arm
□ Left Foot □ Left Leg □ Right Foot □ Right Leg

□ dizziness □ nervousness □ fatigue □ anxiety □ depression □ excessive irritability □ fear of driving in a car
□ jaw clenching □ a loss of concentration □ nightmares □ grinding of teeth at night □ difficulty sleeping

Additional Symptoms/ Complaints:

_____

_____

_____

_____

Initial _____

Have you lost any time from work due to your injuries? □ Yes □ No If yes please give dates: _____ to _____
Type of employment: _____ Have you had previous injuries or accidents? □ Yes □ No
Description of previous Accident(s):_____
Description of similar previous injuries: _____
Is there any residual pain from the previous injury? □ Yes □ No
How much better did you feel prior to your current condition? (Example 100%, 80% etc.) _____%

Anything else the doctor should know about? _____
_____

Thank you!