



Appleton Spine Institute

Chiropractic Care | Pain Management | Rehab

3225 W. Spencer Street • Appleton, WI 54914 • Phone: 920-882-6144 • Fax: 920-882-6142

Personal Injury Questionnaire

Name _____ Phone () _____

Address _____ City _____ State _____ Zip _____

Age _____ Birthdate _____ Sex _____ SS# _____

Employer's Name _____ Employer's Address _____

Your Ins. Co. _____ Policy # _____ Agent's Name _____

Name on Policy (If other than self) _____ Policy # _____

Responsible Party's Name _____

Address _____ City _____ State _____ Zip _____

Policy Holder's Name _____ Policy# _____

ATTORNEY

Name _____ Phone() _____

Address _____ City _____ State _____ Zip _____

Were there any witnesses? () Yes () No Name(s) _____

NATURE OF ACCIDENT:

1. Date of Accident _____ Time of Day _____

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

3. Number of people in your vehicle? _____ Were you wearing seat belts? _____

4. What direction were you headed? () North () East () South () West
on (name of Street) _____

5. What direction was other vehicle headed? () North () East () South () West
on (name of street) _____

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

7. Approximate speed of your car _____ mph Other car _____ mph

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

9. Were police notified? () Yes () No

10. In your own words, please describe accident: _____

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

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 and 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, including date(s) and type(s) of accidents, as well as injury(ies) received. _____

17. Where were you taken after the accident? _____

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

What type of treatment did you receive? _____

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

20. CHECK SYMPTOMS YOU HAVE NOTICED SINCE 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 Ear | <input type="checkbox"/> Hands Cold |
| <input type="checkbox"/> Neck Stiff | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Stomach Upset |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Head Seems Too Heavy | <input type="checkbox"/> Depression | <input type="checkbox"/> Fainting | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Pins & Needles in Arms | <input type="checkbox"/> Lights Bother Eyes | <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> Cold Sweats |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Pins & Needles in Legs | <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Loss of Taste | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Tension | <input type="checkbox"/> Numbness in Fingers | <input type="checkbox"/> Ears Ring | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> _____ |

Symptoms Other Than Above _____

21. Have you lost time from work as a result of this accident? () Yes () No If yes, please complete this question.
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 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, in detail: _____

23. Other pertinent information: _____

