RATHMANN-BOUY CHIROPRACTIC PERSONAL INJURY QUESTIONNAIRE

PLEASE BE VERY SPECIFIC WITH YOUR ANSWERS – Please print

Name_____ Social Security #_____

Address _____
City State Zip Code

Phone: Cell _____ Home _____ Work _____

Sex: Male Female Age_____ Date of Birth_____ Email _____

Height ___'___" Weight_____ Allergies_____

Occupation_____ Employer name_____

Emergency contact: Name_____ Phone _____

Do you have an attorney representing you for your accident: [ ] Yes [ ] No Who?

_____

Are you pregnant? [ ] Yes [ ] No If so, how many weeks? _____

INJURY INFORMATION

Date of Accident_____ Time_____AM/PM

Where did accident occur: _____

Describe the accident in your own words: _____

_____

_____

_____

Road conditions at time of accident: [ ] Rainy [ ] Wet [ ] Clear [ ] Dark [ ] Other _____
Were you the: [ ] Driver [ ] Front Passenger [ ] Rear Passenger [ ] Pedestrian
Did you strike the other vehicle? [ ] Yes [ ] No
Did the other vehicle strike you? [ ] Yes [ ] No
Collision type: [ ] front [ ] Rear [ ] Left (driver side) [ ] Right (passenger side)
If second collision: [ ] front [ ] Rear [ ] Left [ ] Right
Were you wearing a seat belt? [ ] Yes [ ] No
Did you see the accident coming? [ ] Yes [ ] No
Did you brace yourself for impact? [ ] Yes [ ] No
Did an airbag deploy? [ ] Yes [ ] No [ ] Not equipped with airbag
On what part of the vehicle did the following body parts hit (if any):
Head hit_____ Left/Right Shoulder hit: _____
Chest hit:_____ Left/Right arm hit: _____
Left/Right hip hit: _____ Left/Right leg hit: _____
Left/Right knee hit: _____ Other: _____
Did you lose consciousness upon impact? [ ] Yes [ ] No If yes, how long? _____
Were you dazed (unable to think clearly or act normally)? [ ] Yes [ ] No
Please describe how you felt immediately after the accident: _____
_____

What are your major complaints today? _____
_____

Did you go to hospital [ ] Yes [ ] No
When did you go? [ ] right away/Later same day [ ] Next Day [ ] 2 or more days
Were you admitted to the hospital? [ ] Yes [ ] No If yes how long? _____
How did you get to hospital? [ ] Ambulance [ ] Private transportation
Name of hospital: _____
Name of Dr. seen: _____
...what treatment and/or recommendations were given? (Check all that apply)

[ ] Exam [ ] X-rays [ ] CT scan [ ] Stitches [ ] given pain medication
[ ] given instructions regarding sprains and strains [ ] Physical Therapy
[ ] given instructions regarding concussions [ ] instructed to call own doctor
[ ] instructed to call an Orthopedic Surgeon [ ] instructed to call a Neurologist
[ ] Other_____

Have you seen any other doctor as a result of this accident? [ ] Yes [ ] No
Doctor/Facility name _____

_____

_____

Since the accident, are conditions becoming [ ] Better [ ] Worse [ ] Unchanged

Have you lost any time from work due to your injuries? [ ] Yes [ ] No
If yes, please give dates: _____

Check symptoms you have had since the accident:

[ ] Neck pain [ ] Feet/toe numbness [ ] Irritability
[ ] Mid Back pain [ ] Arm/Shoulder pain [ ] Nausea
[ ] Chest pain [ ] Dizziness [ ] Jaw problems
[ ] Low back pain [ ] Ear ringing/buzzing [ ] Memory loss
[ ] Headaches [ ] Vision blurred [ ] Fatigue
[ ] Hand/finger numbness [ ] Sleep difficulty [ ] Shortness of breath.
[ ] Other_____

Please list any of the checked symptoms above that you had before the accident (if any):

_____

_____

_____

Have you ever had any prior automobile accidents or any serious falls/injuries? If yes, please give dates and treatments: _____

_____

Have you had any surgeries? If yes, list date, type & outcome: _____

_____

Have you ever seen a Chiropractor before? If yes, who & what treated for? _____

_____

I AUTHORIZE THIS DOCTOR TO RECEIVE INFORMATION THAT MAY PRETAIN TO MY PRESENT CASE, WHICH MAY BENEFIT MY RECOVERY AS NEEDED. I AGREE TO FOLLOW, AS BEST I CAN, PRESCRIBED THERAPIES AND GUIDELINE FOR MY OWN BENEFIT. I AUTHORIZE ANY OUTSTANDING BILL THAT MAY REMAIN FROM MY TREATMENT TO BE PAID BY THE INSURANCE COMPANY TO THE DOCTOR

PATIENT SIGNATURE: _____ DATE: _____