RATHMANN-RICHARDS 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 may 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: _____