RATHMANN CHIROPRACTIC PERSONAL INJURY QUESTIONAIRE

PLEASE BE VERY SPECIFIC WITH YOUR ANSWERS – Please print

Name_____ ____ _____
Last First M I Nickname

Address _____
City State Zip Code

Mobile Phone_____ **Home Phone** _____ **Work Ph.**_____

Age_____ **Date of Birth**_____ **Social Security #**_____

Please circle all that apply: MALE FEMALE SINGLE MARRIED DIVORCED WIDOWED

Height ___'___" **Weight**_____ **Allergies**_____

Employer Name_____ **Occupation**_____

In case of Emergency, Please 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 happen? 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 your vehicle strike another vehicle [ ] Yes [ ] No
Was your vehicle struck by another vehicle [ ] Yes [ ] No
Angles of impact...First Collision: [ ] front [ ] Rear [ ] Left (driver side) [ ] Right (passenger side)
If second collision: [ ] front [ ] Rear [ ] Left [ ] Right
Were you wearing a seat belt? [ ] Yes [ ] No
Were you: [ ] Surprised by impact [ ] Braced for impact

Did you strike anything in vehicle at time of impact? [ ] Yes [ ] No
If yes, specify what part of your body struck what: ex...head chest shoulder right / left knee
[ ] Steering Wheel_____ **[ ] Dashboard**_____
[ ] Windshield_____ **[ ] Armrest**_____
[ ] Left side door_____ **[ ] Right side Door**_____
[ ] Left side window_____ **[ ] Right side window**_____
[ ] Other_____
Did you lose consciousness? [ ] Yes [ ] No If yes, how long_____
Were you dazed (circumstances unclear)? [ ] Yes [ ] No
Please describe what symptoms you felt:
Immediately after the accident: _____
Later that day: _____
The next day: _____

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 for an overnight stay in the hospital? [ ] Yes [ ] No

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 [ ] given stitches [ ] Bandaged [ ] 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's 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: _____

If you have had any of the following symptoms since your injury, please check

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

[ ] Other_____

Do you have any prior history of any of the symptoms you checked above? [ ] Yes [ ] No, If yes, please explain: _____

_____

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

_____

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

_____

Are you currently under the care of any other doctors for any health related concerns? If yes, please describe. _____

Have you ever seen a Chiropractor before? If yes, then who, where & 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: _____