

**RATHMANN-RICHARDS CHIROPRACTIC PERSONAL INJURY QUESTIONNAIRE**  
PLEASE BE VERY SPECIFIC WITH YOUR ANSWERS - Please print

Name \_\_\_\_\_  
Last First MI 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: \_\_\_\_\_