PERSONAL INJURY QUESTIONNAIRE

Name _____ Date and time of accident _____

Where did accident happen? _____

Describe the accident _____

_____

_____

_____

Make and model of your vehicle _____ Other vehicle _____

Road conditions: ☐ Wet ☐ Dry ☐ Icy ☐ Other _____

What was your position in car? ☐ Driver ☐ Right front ☐ Left rear ☐ Right rear

Your vehicle was: ☐ Stopped at time of impact ☐ Accelerating ☐ Slowing down ☐ At steady speed

Did your vehicle strike other vehicle(s)? ☐ Yes ☐ No

Was your vehicle struck by other vehicle(s)? ☐ Yes ☐ No

Estimated speed of your vehicle _____ MPH

Other vehicle _____ MPH

Was the impact from the: ☐ Front ☐ Right side ☐ Left side ☐ Rear

Did your vehicle roll? ☐ Yes ☐ No

Multiple times? ☐ Yes ☐ No

At time of impact, were you looking: ☐ Straight ☐ Right ☐ Left

Were both hands on steering wheel? ☐ Yes ☐ No

Was your foot on brake? ☐ Yes ☐ No

Were you braced for impact? ☐ Yes ☐ No

Were you wearing a : ☐ Lap belt ☐ Shoulder harness

Are there headrests on seat? ☐ Yes ☐ No

How far is top of headrest or seat back from top of head? _____ inches

Where in the car were you after the accident? _____

Did you strike anything in vehicle at time of impact? ☐ Yes ☐ No

If yes, please specify: ☐ Steering wheel ☐ Dashboard ☐ Windshield ☐ Door ☐ Arm rests ☐ Side Window ☐ Other _____

Please state part of body struck: ☐ Chest ☐ Chin ☐ Knee ☐ Shoulder ☐ Hand ☐ Head ☐ Other _____

What bleeding cut(s) did you receive in the accident? _____

What bruise(s) did you receive in the accident? _____

Were you unconscious? ☐ Yes ☐ No

In a daze? ☐ Yes ☐ No

Did you go to the hospital? ☐ Yes ☐ No

If yes, when? _____

How did you get to the hospital? ☐ Ambulance ☐ Private Trans.

Did attendants place you in: ☐ Brace ☐ Splints ☐ Neck collar

Were you X-rayed at the hospital? ☐ Yes ☐ No

Name of hospital: _____

Attended by doctor named: _____

How long did you stay? _____

What treatment was rendered? _____

Please check symptoms you have noticed since the accident:

☐ Headache	☐ Low back stiffness	☐ Irritability	☐ Constipation	☐ Stomach upset
☐ Head pain	☐ Hip pain stiffness	☐ Chest Pain	☐ Loss of taste	☐ Loss of smell
☐ Neck pain	☐ Nervousness	☐ Dizziness	☐ Arthritis	☐ Fever
☐ Neck soreness	☐ Tension	☐ Head seems too heavy	☐ Numbness in toes	☐ Knee pain
☐ Neck stiffness	☐ Neuritis	☐ Pins & needles in arms	☐ Pins & needles of feet	☐ Leg cramps
☐ Sleeping problems	☐ Face Flushed	☐ Arm pain	☐ Shortness of breath	_____
☐ Shoulder pain	☐ Hands cold	☐ Loss of arm strength	☐ Fatigue	_____
☐ Shoulder stiffness	☐ Loss of hand strength	☐ Buttock pain	☐ Depression	_____
☐ Shoulder tension	☐ Pins & Needles of hands	☐ Pins & needles in legs	☐ Lights bother eyes	_____
☐ Mid back pain	☐ Loss of grip	☐ Numbness in fingers	☐ Loss of memory	_____
☐ Mid back tension	☐ Fainting	☐ Digestive disorders	☐ Ears ring	_____
☐ Pain in ribs	☐ Cold sweats	☐ Feet cold	☐ Anemia	_____
☐ Low back pain	☐ Diarrhea	☐ Loss of balance	☐ Buzzing in ears	_____

Is your pain: ☐ Constant ☐ On and off ☐ Sharp ☐ Dull ☐ Other _____

Presently, pain is increased when you: ☐ Sit ☐ Kneel ☐ Push ☐ Pull ☐ Walk ☐ Bend ☐ Crawl ☐ Lift ☐ Strain ☐ Lift repeatedly ☐ Sneeze ☐ Cough ☐ Reach above shoulders ☐ Crouch ☐ Move bowels ☐ Rise from sitting ☐ Rise from bending

Is it difficult to move around in bed? ☐ Yes ☐ No

Have you had any change in your bowel habits? ☐ Yes ☐ No

Your most comfortable position: ☐ Sitting ☐ Standing ☐ Lying on right side ☐ Lying on left side ☐ Lying on back ☐ Lying on stomach

Have you ever been in an accident before? ☐ Yes ☐ No

If yes, please describe:

	Date	Brief Description
1.	_____	_____
2.	_____	_____
3.	_____	_____

What previous physical complaints if any did you experience immediately prior to this accident? Describe: _____

Were any of these complaints aggravated or made worse by the accident? ☐ Yes ☐ No

If yes, describe: _____

OCCUPATIONAL INFORMATION

What is your occupation? _____ How long? _____

Name of employer? _____

Have you lost any time from work because of this accident? ☐ Yes ☐ No

If yes, give dates of time lost. From _____ To _____

Totally disabled from _____ to _____

Partially disabled from _____ to _____

Are you now limited in your lifting ability in some body position that you were previously not? ☐ Yes ☐ No

What symptoms does lifting produce: _____

How long do these symptoms last? _____

What positions can you work in with a MINIMUM DEMAND of physical effort? ☐ Standing ☐ Walking ☐ Sitting

With Minimum Demand of physical effort, what positions can you work in PART-TIME and for how long? ☐ Standing _____ ☐ Walking _____ ☐ Sitting _____

With Minimum Demand of physical effort, can you work in a SITTING POSITION with some degree of walking or standing activity? ☐ Yes ☐ No

Do you feel that you cannot perform any physical work activity? ☐ Yes ☐ No

Do you feel that you cannot perform any mental work? ☐ Yes ☐ No

Generally speaking, is your inability to perform these functions due to: ☐ Pain ☐ Weakness ☐ Nerves ☐ Structural limitations

Any sexual impairment since accident? ☐ Yes ☐ No

Are you able to take care of your personal self, such as dressing, bathing, etc? ☐ Yes ☐ No

Or do you require assistance? ☐ Yes ☐ No

Do you feel your present condition is temporary? ☐ Yes ☐ No

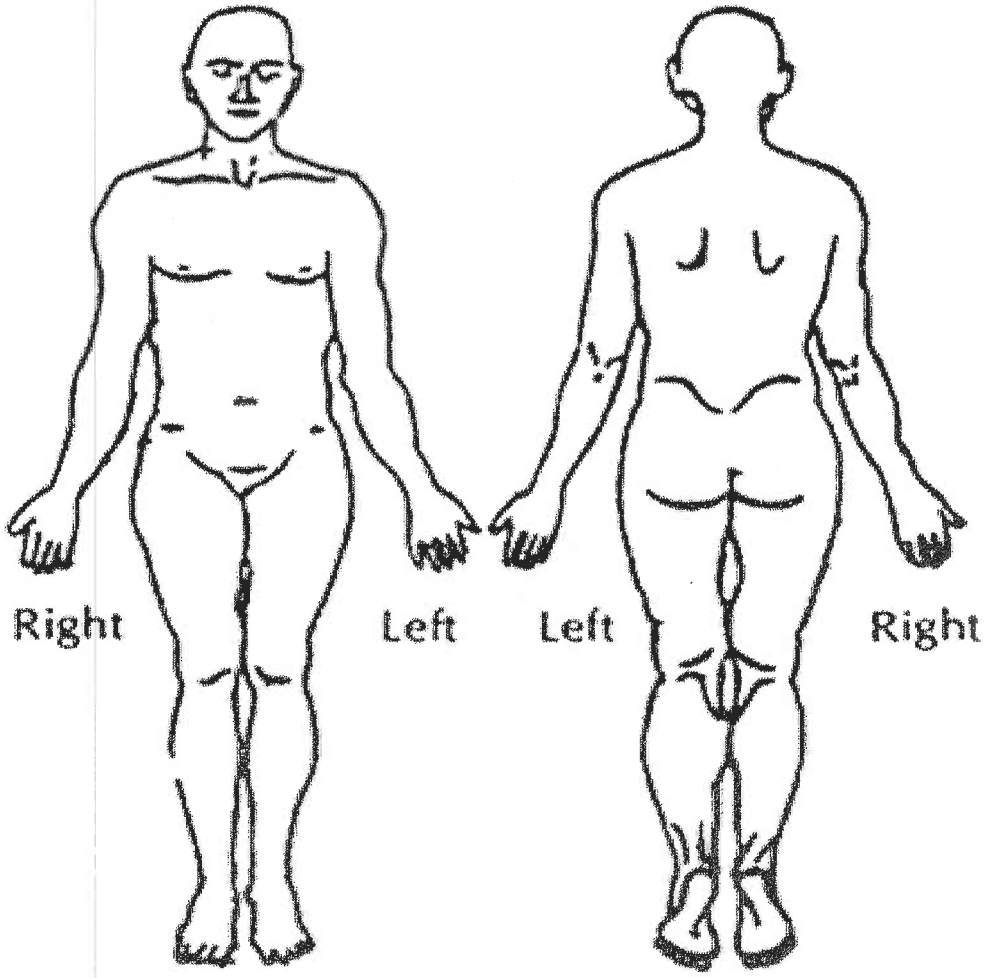
Or permanent? ☐ Yes ☐ No

Signed _____

Name _____ **Date** _____

Please fill this out accurately. Use no symbols except those indicated. Mark the areas on your body where you feel the described sensation. Use the appropriate symbol. Mark areas of radiation. Include all affected areas.

Numbness +++ **Burning Pain** 000 **Sharp, Stabbing Pain** /// **Aching Pain** (((



RATE YOUR PAIN:

	0 = No Pain									**10 = Extremely Intense Pain**
1. Right Now	0	1	2	3	4	5	6	7	8	9	10
2. At its Worst	0	1	2	3	4	5	6	7	8	9	10
3. At its Best	0	1	2	3	4	5	6	7	8	9	10

AUTO ACCIDENT INSURANCE INFORMATION

DO YOU HAVE **MED-PAY BENEFITS** FROM YOUR **CAR INSURANCE**? If so, complete the following:

Insurance Company _____

Mailing Address _____
_____
_____

Phone # _____
Adjuster name _____
Policy Holder _____
Claim Number _____

DO YOU HAVE A **GENERAL HEALTH INSURANCE POLICY** THAT WILL COVER YOUR ACCIDENT CLAIM? Some general health insurance companies will deny benefits if an auto insurance carrier is primarily responsible for your medical bills. If you have a plan that will cover your claims, please complete the following:

Insurance Company _____

Mailing Address _____
_____
_____
_____

Insured Name _____
Insured's SS# _____
Group Number _____

DO YOU HAVE AN **ATTORNEY TO REPRESENT YOU** FOR THIS ACCIDENT? If so, complete the following:

Attorney _____

Mailing Address _____
_____
_____
_____

IT IS IMPORTANT THAT THIS INFORMATION BE FILLED OUT **ACCURATELY AND COMPLETELY**. THIS WILL HELP YOU OBTAIN BENEFITS PROMPTLY.

SLO WELLNESS CENTER

Casparian Chiropractic, Inc.
Aram Casparian, DC

Stevens Chiropractic, Inc.
Rex Stevens, DC
Molly Stevens, DC

Sachs Chiropractic, Inc.
Sandy Sachs, DC

805.543.8688 (phone)
805.543.8732 (fax)

1428 Phillips Lane, Suite 300
San Luis Obispo, CA 93401
www.slowellness.com

Doctor's Lien

Doctor: _____

1428 Phillips Lane, Ste 300

San Luis Obispo, CA 93401

(805) 543-8688

3rd Party Auto insurance Information

Insurance company name _____

Adjuster name _____

Phone number _____

Claim number_____

Date of injury _____

I understand that I am directly and fully responsible to said doctor for all treatment and medical bills submitted by him/her for services rendered to me and this agreement is made solely for the said doctor's additional protection and in consideration of his/her awaiting payment. I agree to pay a partial payment of _____per visit (and _____ on the initial visit). I further understand that upon settlement with the 3rd party, I am responsible to pay the balance due in full immediately.

_____

Patient Signature Date

_____

Print Name