SCHILSKY CHIROPRACTIC CENTER

Account #_____

312 Dolphin Drive
Jacksonville, North Carolina 28546
910-347-4033

PERSONAL INJURY QUESTIONAIRE

(PLEASE BE VERY SPECIFIC WITH YOUR ANSWERS…THANK YOU!)

NAME: _____DATE: _____

CHIEF COMPLAINT:

1. Describe your current complaint that you are requesting evaluation and treatment for from this office. Please check the symptoms that you have since the accident: _____

_____

☐ Headaches	☐ Numbness in toes	☐ Loss of Memory	☐ Pain Behind Eyes
☐ Neck Pain/Stiffness	☐ Arm/ Leg Weakness	☐ Dizziness	☐ Clicking/Popping Jaw
☐ Mid Back Pain	☐ Sleeping Problems	☐ Numbness in fingers	☐ Facial Pain
☐ Low Back Pain	☐ Eyes Light Sensitive	☐ Fainting	☐ Irritability
☐ Arm Pain	☐ Fatigue	☐ Breath Shortness	☐ Loss of Balance
☐ Leg Pain	☐ Depression	☐ Ringing/Buzzing	☐ Cold Feet
☐ Muscle Spasm/Cramping	☐ Cold hands	☐ Chest Pain	
☐ Pain across Shoulder Blades	☐ Diarrhea	☐ Constipation	

2. Do you have any prior history of any of the symptoms you checked above? ☐ Yes ☐ No If yes explain: _____
_____

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

4. Please describe your accident in your own words: _____
_____

HISTORY:

5. What was the Date of the Accident? _____ Time: _____ AM/PM _____
6. How many vehicles were involved in the accident?_____
7. What was the estimated damage to the vehicle you were in?_____
8. What street or intersection were you on when the accident occurred?_____
9. What city did the accident occur in?_____ State:_____
10. What direction were you traveling in? North____ South_____ East_____ West_____
11. What type of impact was the auto accident? (check all that apply) ☐ Head-on Collision ☐ Front Impact ☐ Broad-side Collision ☐ Rear-end car in front of you ☐ Rear Impact ☐ Non-collision
12. Did your vehicle hit anything following the accident?_____
13. Where were you sitting in the vehicle during the accident?_____
14. Who was the driver of your car? _____
15. Did you know the accident was coming?_____
16. What type of vehicle were you in? (Year & Model)_____
17. What type of vehicle impacted yours? (Year & Model of other car) _____
18. Was your vehicle….slowing down__ Speeding up___ Moving at a steady speed___ Stopped __ Other_____
19. Was the other car… slowing down__ speeding up____ Moving at a steady speed____Stopped __ Other_____
20. At the time of impact, how fast would you estimate the other vehicle was moving?_____
21. During and after the crash what happened to your vehicle? (check all that apply)
    ____Kept going straight _____spun around _____kept going straight hitting a car in front _____ hit a stationary object
    _____spun around & hit a stationary object _____was hit by another vehicle
22. Did you lose consciousness during the accident? ☐ Yes ☐ No
23. How was your head positioned during the accident?_____
24. How was your body positioned during the accident?_____

over please

25. Where were your feet positioned during the accident? _____
26. Did your face hit anything during the accident? ☐ No ☐ Yes, please describe: _____
27. Did your shoulders hit anything during the accident? ☐ No ☐ Yes, please describe: _____
28. Did your neck hit anything during the accident? ☐ No ☐ Yes, please describe: _____
29. Did your chest hit anything during the accident: ☐ No ☐ Yes, please describe: _____
30. Did your hips hit anything during the accident? ☐ No ☐ Yes, please describe: _____
31. Did your knees hit anything during the accident? ☐ No ☐ Yes, please describe: _____
32. Did your feet hit anything during the accident? ☐ No ☐ Yes, please describe: _____
33. What kind of headrest was in your vehicle? _____movable fixed headrest _____non-movable fixed headrest _____no headrest
34. Where was the headrest positioned on your head?_____
35. Did you have your seatbelt on during the accident? ☐ No ☐ Yes
36. Did you slide out of your seatbelt during the accident? ☐ No ☐ Yes
37. What was damaged in your vehicle: (Check all that apply)

___windshield ___rear bumper ___mirror ___steering wheel ___front bumper __knee bolster
___dashboard ___trunk ___back right door ___seat frame ___front left door
___side window ___rear window ___back left door ___front right door ___completely totaled

38. Choose the items that dented inward: ___floorboards ___side door ___dashboard
39. Choose the doors that would not open as a result of the accident:
_____front left _____front right _____rear left _____rear right
40. Did you go to the hospital? No__ Yes__
41. How did you get to the hospital?___ Ambulance ____drove self ___someone else drove
42. What was the name of the hospital?_____
43. Did you stay overnight? ___Yes ___ No
44. Did you receive any of the following at the hospital:
_____pain medication _____muscle relaxer _____neck brace _____stitches
_____MRI _____examination _____x-rays _____CAT scan _____cast
45. Did you receive any stitches for any cuts at the hospital?_____.
46. Were x-rays taken at the hospital? If yes, which area was taken?_____
47. Who was the 1st Doctor that treated you?
Name: _____
Date seen: _____
Were you examined? ☐ Yes ☐ No
Were X-rays taken? ☐ Yes ☐ No Were you: ☐ Sitting or ☐ Standing
Did you receive treatment? ☐ Yes ☐ No ☐ Medications ☐ Braces ☐ Collars
If yes, what kind of treatment did you receive? _____
What benefits did you receive from the treatment? _____
48 What relieves your symptoms? _____
49. What aggravates your symptoms? _____
50. Road conditions at time of accident: ☐ Icy ☐ Rainy ☐ Wet ☐ Clear ☐ Dark ☐ Other (describe): _____
51. Visibility at the time of the accident? ☐ Poor ☐ Fair ☐ Good ☐ Other: _____
52. Where was your car struck? _____
53. Were you wearing a hat or glasses? ☐ Yes ☐ No
If yes, where were they located after the accident? _____
54. Did you get any bleeding cuts? ☐ Yes ☐ No If yes, where? _____
55. Did you get any bruises? ☐ Yes ☐ No If yes, where? _____
56. As a result of the accident you were: ☐ Rendered unconscious ☐ In shock ☐ Dazed, circumstances vague
☐ Other: _____.
57. Are you pregnant? ____NO ____Yes If yes, how far along?_____
58. Do you have an attorney representing you for this claim? ☐ Yes ☐ No
If yes, who? _____

SIGNATURE OF PATIENT: _____ DATE: _____

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