DAVEN L. SPENCER, D.C.

Dedicated to Quality Chiropractic Care, NOT Quantity Care!

PERSONAL INJURY QUESTIONNAIRE

Name _____ Date of Birth _____ Phone _____

Address _____ City _____ State_____ Zip_____

Employer's Name_____ Employer's Address_____

Your Ins. Co._____ Policy #_____ Agent's Name_____

Driver/Other Vehicle _____ Ins. Co. _____ Policy #_____

Have you retained an attorney? ( ) Yes ( ) No Name _____

Were there any witnessess? ( ) Yes ( ) No Name(s) _____

NATURE OF ACCIDENT:

1. Date of Accident _____Time of Day_____
2. Were you: ( ) Driver ( ) Passenger ( ) Front Seat ( ) Back Seat
3. Number of people in your vehicle?_____ Other vehicle?_____
4. What direction were you headed? ( ) North ( ) East ( ) South ( ) West
   on (name of street) _____
5. What direction was other vehicle headed? ( ) North ( ) East ( ) South ( ) West
   on (name of street) _____
6. Were you struck from: ( ) Behind ( ) Front ( ) Lett side ( ) Right side
7. Were you knocked unconscious? ( ) Yes ( ) No. If yes, for how long?_____
8. Were police notified? ( ) Yes ( ) No
9. In your own wcrCs. please describe accident: _____

_____

_____

_____

10. Did you nave any physical complaints BEFORE THE ACCIDENT? ( ) Yes ( ) No. If yes, please describe in detail:

_____

_____

_____

11. Please describe how you feat:
    a. DURING the accident _____
    b. IMMEDIATELY AFTER the accident._____
    c. LATER THAT DAY._____
    d. THE NEXT DAY:_____
12. What are your PRESENT complaints and symptoms?_____

_____

_____

_____

13. Do you have any congenital (from K(liq factors whicn relate to this problem? ( )Yes ( )No. If yes, please describe: _____

_____

14. Do you have any (p revious illnesses which relate to :his case? ( )Yes ( )No. If yes, please describe: _____

_____

15. Have you ever been involved in an accident before? ( )Yes ( )No. If yes, please describe, including date(S) and type(s) of accidents. as well as injury(ies) received._____

_____

_____

16. Where were you taken after the accident? _____

17. Have you been treated by another doctor since the accident? ( ) Yes ( ) No. If yes, please list doctor's name and address:

_____

What type of treatment did you receive? _____

_____

18. Since this injury occurred. are your symptoms: ( ) Improving ( ) Getting Worse ( ) Same

19. CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT:

( ) Headache	( ) Irritablily	( ) Numbness in Toes	( ) Face Flushed	( ) Feet Cold
( ) Neck Pain	( ) Chest Pain	( ) Shortness of Breath	( ) Buzzing in Ears	( ) Hands Cold
( ) Neck Stilt	( ) Neck Stilt	( ) Fatigue	( ) Loss of Balance	( ) Stomach upset
( ) Sleeping Problems	( ) Sleeping Problems	( ) Depression	( ) Fainting	( ) Constipation
( ) Back Pain	( ) Back Pain	( ) Lights Bother Eyes	( ) Loss of Smell	( ) Cold Sweats
( ) Nervousness	( ) Nervousness	( ) Loss of Memory	( ) Loss ol Taste	( ) Fever
( ) Tension	( ) Tension	( ) Ears Ring	( ) Diarrhea	( ) _____

20. Have you lost time from work as a result of this accident? ( ) Yes ( ) No. If yes, please complete this question.

a. Last Day Worked: _____

b. Type of Employment: _____

c. Present Salary: _____

d. Are yOu being compensated for time lost from work? ( ) Yes ( ) No. If yes, please state type of compensation you are receiving: _____

_____

21. Do you notice any activity restrictions as a result of this injury? ( ) Yes ( ) No. If yes. please describe. in detail:

_____

_____

_____

22. Other pertinent information_____

_____

_____

_____ _____

Date Patients Signature