Dr. Frank Panoussi, D.C.

Personal Injury Questionnaire

Name: ____ **Date:**____________

Date of accident:_____________________________ **Time:** __________ AM/PM

You were: ( )Driver ( )Front Passenger ( )Rear Passenger **Number of people in your vehicle:** ___

Who owns the car you were in?____

Your vehicle was: ( ) Stopped ( ) Moving ( ) Starting to move ( )Slowing down

Your vehicle was struck from: ( ) Back ( ) Front ( ) Right side ( ) Left side

Type of accident: ( ) Head-on collision ( ) Front impact ( ) Broad-side collision
( ) Side swiped ( ) Rear-end ,car in front ( ) Rear impact
( ) Non-collision ( ) Pushed striking another vehicle

In your own words, please describe the accident:____
____
____
____

At the time of accident, recall if any parts of your body hit any parts of the inside of your car: ___
____
____
____

Were seat belts worn? ( )Yes ( ) No

Did you see the accident coming? ( )Yes ( ) No **Did you brace for impact?**( )Yes ( )No

Following the impact: ( )Lost consciousness ( ) Blacked out ( )Denies loss of consciousness
( )Has poor recollection of events ( )Other :_____________________

Please describe how you felt immediately after the accident:

( )Nervous ( )Scared ( )Shaky ( )Shocked ( )Confused
( )Dazed ( )Lightheaded ( )Dizzy ( )Nauseous ( )Vomiting
( )Other:____

Within the next morning, you felt: ____

Since the injury occurred symptoms are: ( )Improving ( )Same ( )Worse

Was police report made? ( )Yes ( )No

Were you treated by paramedics at the scene? ( )Yes ( )No

"Yes" what was done? ____

Afterwards, did you go to the emergency room? ( )Yes ( )No

"Yes" hospital's name: ___________________________ Admitted/Discharge **First visit Date:** _______

What was done at the hospital? ( )Examination ( )X-ray ( )Medication ( )Brace ( )Other____

Were you seen by another doctor or clinic before coming to our office? ( )Yes ( )No

"Yes" name: ____________________________________ **First visit Date:** ______________________

What was done? ( )Examination ( )X-ray ( )Medication ( )Brace ( )Other_________________

Did you receive treatment? ( )Yes ( )No

"Yes" what kind of treatment did you receive?( )Chiropractic ( )Physical therapy ( )Other______

What did You do to help your condition at home? ( )Rest ( )Over the counter pain medication
( )Ice ( )Heat ( )Other:_____________________________

Prior to this accident were you experiencing any similar physical complaints? ( )Yes ( )No

"Yes" please describe: ____

Patient's Signature: ____