THE CHIROPRACTIC OFFICE
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MVA PERSONAL INJURY QUESTIONNAIRE

Name _____ Date _____

Address _____ Phone#: _____

SSN _____ Date of Birth _____

Were you performing job related duties when this accident occurred? ❍ Yes ❍ No

Date of Accident _____ Time of Accident _____

Do you have PIP Insurance? ❍ Yes ❍ No Your Insurance Company _____

Claim # _____ Policy Number _____

Other Driver's Insurance Company _____ Policy # _____

Please describe the accident in your own words: _____

_____

_____

_____

Were you the ❍ Driver ❍ Rear Passenger ❍ Front Passenger ❍Other

How many people were in your vehicle? _____ Other Vehicle?_____

ACCIDENT SITE

Road / Street Name _____

City / State _____

Nearest Intersection with road/street _____

Driving Conditions ❍ Dry ❍ Wet ❍ Icy ❍ Other

Which direction were you headed? _____

Speed you were traveling? _____

VEHICLE

Make, model and year of vehicle you were in: _____

_____

Were you wearing a seatbelt? ❍ Yes ❍ No
If yes, what type? ❍ Lap ❍ Shoulder

Was vehicle equipped with airbags? ❍ Yes ❍ No
If yes, did they inflate properly? ❍ Yes ❍ No

Did your seat have a headrest? ❍ Yes ❍ No

OTHER VEHICLE

Make and model of other vehicle _____

Which direction was other vehicle headed? _____

Approximate speed other vehicle was traveling _____

IMPACT

Did your car impact another vehicle? ❍ Yes ❍ No

Did your car impact a structure? _____

Did any part of your body strike anything in the vehicle? ❍Yes ❍No If yes, explain _____

_____

Was impact from :❍ Front ❍ Rear ❍ Left ❍ Right

At the time of impact were you?

❍ Looking straight ahead ❍Looking to the right
❍ Looking to the left ❍ Looking down
❍ Looking up

Were both hands on the steering wheel? ❍Yes ❍No

Was your foot on the brake? ❍ Yes ❍ No

Were you: ❍Surprised by impact ❍Braced for impact

POLICE

Did the police come to the accident site? ❍Yes ❍No

Were there any witnesses? ❍ Yes ❍ No

Was a police report filed? ❍ Yes ❍ No

Was a traffic violation issued? ❍ Yes ❍ No
If yes, to whom? _____

PATIENT CONDITION

Were you unconscious immediately after the accident? ❍ Yes ❍ No If yes, for how long?_____

Please describe how you felt immediately after the accident: _____

_____

TREATMENT

Did you go to the hospital? ❍Yes ❍ No

When did you go? ❍ Immediately after the accident ❍ Next Day ❍ 2 days or more after the accident

How did you get to the hospital? ❍ Ambulance ❍ Private transportation

Name of treating Doctor _____

Diagnosis _____

Treatment received _____

_____

X-rays taken _____

SYMPTOMS/INJURIES

Have you been able to work since the injury? ❍ Yes ❍No How many work days have you missed? _____

Prior to the injury were you able to work on an equal basis with others your age? ❍ Yes ❍ No

If you have had any of the following symptoms since your injury, please indicate

❍ Anxiety	❍ Ear buzzing	❍ Jaw problem	❍ Sensitivity to light
❍ Arm/shoulder pain	❍ Ear ringing	❍ Leg pain	❍ Shortness of breath
❍ Back pain	❍ Fainting	❍ Loss of taste/smell	❍ Sleep difficulty
❍ Back stiffness	❍ Fatigue	❍ Memory loss	❍ Stitches/cuts
❍ Bruising	❍ Feet/toe numbness	❍ Muscle spasms	❍ Stomach upset
❍ Burns	❍ Hand/finger numbness	❍ Nausea	❍ Tension
❍ Chest pain		❍ Neck pain	❍ Tingling
❍ Depression	❍ Headaches	❍ Neck stiff	❍ Vision blurred
❍ Dizziness	❍ Irritability	❍ Radiation of pain	

Is this condition getting progressively worse? ❍ Yes ❍ No ❍ Unknown

Rate the severity of your pain on a scale from 1 (least pain) to 10 _____

Type of pain: ❍ Sharp ❍ Dull ❍ Throbbing ❍ Numbness
❍ Aching ❍ Shooting ❍ Burning ❍ Tingling
❍ Cramps ❍ Stiffness ❍ Swelling ❍ Other _____

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your: ❍ Work ❍ Sleep ❍ Daily Routine ❍ Recreation

Activities or movements that are painful to perform:

❍ Sitting ❍ Standing ❍ Walking ❍ Bending ❍ Lying down

I certify that the above information is correct to the best of my knowledge.
As part of our collection practices, we reserve the right to invoke the use of a medical lien.

Patient Signature _____ Date _____