

Hurst Chiropractic, P.C.

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PERSONAL INJURY QUESTIONNAIRE

Motor Vehicle Accident

Name: _____ Today's Date: _____

Your auto insurance company: _____ Policy # _____ Claim #: _____

Your auto insurance agent: _____ Was an accident report filed with the police? Yes No

Driver of other vehicle: _____ Insurance company: _____ Claim #: _____

Have you retained an attorney? Yes No

Attorney's Name

Firm Name

Phone

Nature of Accident

Date of Accident: _____ Time of day: _____ A.M. P.M.

Location: _____

Intersecting with: _____

Police Investigation by:

Washington State Patrol Wenatchee Police East Wenatchee Police

Chelan County Sheriff Douglas County Sheriff Other _____

No investigation

Road conditions at the time of accident: Dry Wet Icy Snow Other: _____

Where were you seated in the vehicle? Driver Front seat passenger Back seat passenger

Were you aware of the approaching collision prior to impact or were you caught by surprise?

Aware of the approaching collision Caught by surprise

Did you lose consciousness (blackout) upon impact? Yes No

If yes, can you estimate for how long? _____

Was your vehicle equipped with a headrest? Yes No

Were you wearing a seat belt? Yes No

If so, what type? Lap belt only Shoulder and lap belt

Is your car equipped with an airbag? Yes No

If yes, did the air bag activate? Yes No

Were you struck from:

Behind Front Left side Right side

Was your car stopped at the time of impact? Yes No

If yes, was the driver's foot on the brake? Yes No Don't know

If the driver's foot was on the brake, was it pressing down: Slightly Moderately Strongly

If no, then estimate the speed of the vehicle you were in: _____ m.p.h.

If your vehicle was moving at the time of the collision, was it slowing down, gaining speed, or traveling at a steady speed?

Slowing down Gaining speed Steady speed

Number of people in your vehicle? _____

Please describe, to the best of your knowledge, what happened during this accident: _____

What type of car were you in? (year, make, and model) _____

What type of car impacted with your vehicle? (year, make, and model) _____

Was the other vehicle moving at the time of the collision? Yes No

If yes, what was its approximate speed: _____ m.p.h.

If the other vehicle was moving at the time of the collision, was it slowing down, gaining speed, or traveling at a steady speed?

Slowing down Gaining speed Steady speed

What bruises or cuts did you get from the accident? _____

On what part of the automobile did the following body parts hit:

Head hit _____

Chest hit _____

Right shoulder hit _____ Left shoulder hit _____

Right arm hit _____ Left arm hit _____

Right hip hit _____ Left hip hit _____

Right leg hit _____ Left leg hit _____

Right knee hit _____ Left knee hit _____

Other _____

What position was your head facing upon impact?

Forward Turned to the right Turned to the left Other _____

What position was the trunk of your body facing upon impact?

Forward Turned to the right Turned to the left Other _____

Was your vehicle pushed forward from the impact? Yes No

If yes, how much? More than one car length One-half car length
 One car length Less than one-half car length

Did your car hit anything else after it was hit? _____

Describe the damage to your vehicle: None Minimal Moderate Major Totaled

Which of the following car parts broke during the accident?

Windshield Front seat back Driver's side window Passenger side window Steering wheel
 Other _____

Estimate given for damage to your vehicle: \$ _____ Estimate not yet obtained

Describe the damage to other vehicle(s): None Minimal Moderate Major Totaled

Who was at-fault for the accident?

Driver of other car Driver of car I was in Myself Undetermined

Was anyone cited? _____

Emergency Care

At the site of the accident, did you receive emergency care? [] Yes [] No

Describe: _____

Where did you go after the accident? [] Emergency room [] Physician's office [] Home [] School [] Work

When did you receive care? [] Immediately [] Later that day [] Next day [] Days later, date: _____

By whom were you driven? [] Ambulance [] Self [] Family Member [] Friend

Treatment

Hospital Name: _____ (or) Other medical facility: _____

What type of treatment did you receive? _____

X-rays: _____ Medication prescribed: _____

What recommendations were you given? _____

Have you been treated by any other doctor(s) for injuries related to this accident? [] Yes [] No

If yes, please list doctors and briefly describe treatment:

1. _____ Dates of care: _____ Type of Care: _____

2. _____ Dates of care: _____ Type of Care: _____

3. _____ Dates of care: _____ Type of Care: _____

4. _____ Dates of care: _____ Type of Care: _____

Present Symptoms

What are your present complaints and symptoms? _____

When did your pain begin? _____

Did you have the same or similar symptoms before the accident? [] Yes [] No. If yes, describe any changes or worsening:

Prior History

Have you ever been involved in a motor vehicle accident before? [] Yes [] No. If yes, briefly describe, including dates and injuries received: _____

Patient's Signature _____