David G. Ramaley N.D., D.C., D.A.C.N.B., Laurie McQuaig D.C., D.A.C.N.B., 12345 Roosevelt Way NE, Suite 101 Seattle WA 98125 206-306-7797

PERSONAL INJURY QUESTIONNAIRE

PERSONAL INFO:

Name: Phone:

Address: City/State/Zip:

Social Security #: Sex: M F Birth Date:

Single Married Partnered Partner/Spouse's name:

Occupation:

Employer's Name: Business phone:

Whom may we thank for referring you?

In case of emergency whom should be notified?

Relation to Patient: Phone:

INSURANCE INFORMATION: *personal injury protection/auto*

Car Driver's Ins. Co: Claim#:

Adjustor's Name: Adjustor's Phone:

Driver's Name if not patient:

Attorney's Name (if have one): Attorney's Phone #:

NATURE OF ACCIDENT:

Date of accident: Time of Day:

Were you: Driver Passenger Front seat Back seat

Number of people in your vehicle? Were you wearing seat belts?

What direction were you headed? East West South North

Were you struck from: Front Left Right Behind

Approximate speed of your car: mph Other car: mph

Were you knocked unconscious? Yes No If yes, how long?

Were police notified? Yes No

In your own words, describe the accident:

Did you have any physical complaints before the accident? Yes No If yes, please describe:

David G. Ramaley N.D., D.C., D.A.C.N.B., Laurie McQuaig D.C., D.A.C.N.B., 12345 Roosevelt Way NE, Suite 101 Seattle WA 98125 206-306-7797

Please describe how you felt:

During the accident:

IMMEDIATELY AFTER the accident:

Later that day:

The next day:

What are your PRESENT complaints and symptoms?

Do you have any congenital factors that relate to this problem? Yes No If yes, please describe

Do you have any previous illnesses that relate to this accident? Yes No If yes, please describe

Where were you taken after the accident?

Have you been treated by another doctor since the accident? Yes No

If yes, please list doctor's name and phone number:

Circle symptoms you have noticed since accident:

headache	numbness	face flushed	irritability	feet cold
neck pain	shortness of breath	buzzing in ears	chest pain	hands cold
neck stiffness	fatigue	loss of balance	head seems to heavy	stomach upset
sleeping problems	depression	fainting	dizziness	fever
back pain	lights bother eyes	loss of smell	pins & Needles in arms	cold sweats
nervousness	loss of memory	loss of taste	Pins & Needles in legs	constipation
tension	ears ringing	diarrhea	numbness in fingers	

Have you lost time from work as a result of this accident?: Yes No If yes, please complete the following question

What was your last day worked?:

Are you being compensated for time lost from work?: Yes No If yes, please state type of compensation

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

Health History:

Please list any allergies:

Please list medications currently taking:

Please list any previous surgeries:

Have you ever been involved in an accident before? Yes No If yes, please describe

Other pertinent information:

Patient Signature: **Date:**