City Fit Family Chiropractic Center LLC | 319 SW Washington St, Ste 1001, Portland OR 97204 | 503-224-5010

PERSONAL INJURY / AUTO ACCIDENT QUESTIONNAIRE

NAME: **DOB:** **Date:**

Date of Accident: **Insurance Company:** **Claim#:**

Where did accident happen? Describe the accident in your own words:

What was your position in the car?

Driver: Were your hands on the steering wheel? ☐ Left ☐Right ☐Both

Passenger: Were you sitting in ☐Front ☐Right Rear ☐Left Rear

Did your vehicle strike another vehicle ☐Yes ☐No

Was your vehicle struck by another vehicle ☐Yes ☐ No

Angles of impact… First Collision: ☐ Front ☐ Back ☐ Left ☐ Right

If Second Collision: ☐ Front ☐ Back ☐ Left ☐Right

Were you wearing a seat belt? ☐Yes ☐ No

Did you brace for impact? ☐Yes ☐No … ☐I braced with my hands ☐I braced with my feet

Which way were you facing at the time of impact… ☐straight ahead ☐Left ☐Right

Did you strike anything in vehicle at time of impact? ☐Yes ☐ No

If yes, specify what part of your body struck what: ie… head chest chin shoulder

☐Right / Left Knee ☐Steering Wheel ☐Dashboard

☐ Windshield ☐ Roof ☐Left Side Door

☐ Right Side Door ☐ Left Side Window ☐ Right Side Window

☐ Other____

Did the seat back bend / break ? ☐ Yes ☐ No Did you lose consciousness? ☐ Yes ☐ No

Immediately following the accident, how did you feel?

☐ dizzy/dazed ☐ disoriented ☐ nervous ☐ nauseous ☐ upset ☐ weak ☐ Other

Did emergency services come to the scene of the accident? ☐Yes ☐No

Did you file a police report? ☐Yes ☐No

Did you go to an emergency room, hospital or urgent care after the accident? ☐ Yes ☐No

If you went to the hospital/ER, when did you go? ☐At time of accident ☐Next day

How did you get to the hospital/ER? ☐Ambulance ☐Police Car ☐Private Transportation

Name of Hospital/ER/Urgent Care:____

What treatment was given?

☐none ☐placed in a cervical collar ☐x-rayed ☐ given stitches ☐bandaged

☐ given pain medication _______________________________________

☐given instructions regarding concussions

☐given instructions regarding sprains and strains

☐ Physical Therapy ☐instructed to call a Orthopedic Surgeon

☐instructed to call a private physician ☐referred to this office for treatment

☐ Other_________________________

Have you seen any other doctor as a result of this accident? ☐ Yes ☐No

Doctor's name/address

CHIEF COMPLAINTS AND SYMPTOMS

Name: **DOB:** **Date:**

Accident Date:

Please mark any of the following that are currently bothering you as a result of the accident.

☐**Neck pain**	Onset: ☐ immediately after accident ☐ several hours later ☐ next day ***Select areas of radiation, if any:*** ☐none ☐left shoulder ☐left arm ☐left forearm ☐left hand ☐right shoulder ☐right arm ☐right forearm ☐right hand
☐Headache	Onset: ☐ immediately after accident ☐ several hours later ☐ next day
☐Migraine Headache	Onset: ☐ immediately after accident ☐ several hours later ☐ next day
☐Upper back pain	Onset: ☐ immediately after accident ☐ several hours later ☐ next day

Ringing in Ears	☐Yes	☐No	☐Left	☐Right	☐Both Ears
Blurry Vision	☐Yes	☐No	☐Left	☐Right	☐Both Eyes
Wrist Pain	☐Yes	☐No	☐Left	☐Right	☐Both Wrists
Jaw Pain	☐Yes	☐No	☐Left	☐Right	☐Both Sides

☐dizziness ☐ balance problems ☐nervousness ☐fatigue ☐anxiety ☐depression ☐excessive irritability
☐fear of driving ☐ loss of concentration ☐jaw clenching ☐grinding of teeth at night ☐nightmares
☐difficulty with sleeping (falling asleep, staying asleep)

☐**Low Back Pain**	Onset: ☐ immediately after accident ☐ several hours later ☐ next day ***Select areas of radiation, if any...*** ☐none ☐buttocks ☐left buttock ☐left thigh ☐left knee ☐left foot ☐right buttock ☐right thigh ☐right knee ☐right foot

Hip Pain	☐Left	☐Right	☐Bilateral
Knee Pain	☐Left	☐Right	☐Bilateral
Foot Pain	☐Left	☐Right	☐Bilateral

Numbness:

Onset - ☐ immediately after accident ☐ several hours later ☐ next day

☐ Left Hand	☐Left Upper Arm	☐Right Hand	☐Right Upper Arm
☐ Left Foot	☐Left Leg	☐Right Foot	☐Right Leg

Additional Symptoms/ Complaints:

Have You lost any time from work due to your injuries? ☐Yes ☐No

If yes please, give dates: ____

Type of work / employer: ____

Have you had other recent injuries or accidents? ☐Yes ☐No

Description of previous accident: ____

Description of previous injuries: ____

Is there any residual pain from the previous injury or accident? ☐Yes ☐No

How much better did you feel prior to your current condition? (Example 100%, 80% etc.)

____