LIFETIME
WELLNESS & CHIROPRACTIC

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Phone: (303) 399- 3569 Fax: 888-830-1498

PERSONAL INJURY QUESTIONNAIRE

Name_____ Date_____
Address _____City_____ State ___ Zip _____
Home # _____ Work # _____ Cell # _____
Email Address _____ Social Security # _____
Birth date _____ Age ____Sex: M/F Marital Status: single married widowed divorced separated
Business Employer _____ Type of work _____
Spouse's name _____ Ages of kids _____
Whom may we thank for referring you? _____

Your Insurance Information (regardless of who is at fault)

Insurance Company _____ Phone # _____
Adjusters Name _____ Claim number_____
Do you have Medical Payments (MedPay) Protection on your car insurance policy? Yes No
What is your health insurance carrier? _____
***** We will need to make copies of your different insurance information, please see front desk *****

Do you have an attorney? Yes No
Name _____ Phone _____

Nature of Accident

Who was at fault? _____ Date of accident _____ Time of day _____
Were you: ___ Driver ___ Passenger ___ Front-seat ___ Back-seat
Were you wearing a seatbelt? Yes No Did an airbag release? Yes No
Does your car have headrests? Yes No
If yes, what height was it at time of impact? ___ Bottom of neck ___ Bottom of head ___ Middle of head
What direction were you headed? ___ North ___ South ___ East ___West
Were you struck from: ___ Behind ___ Front ___ Left-side ___ Right-side
Approximate speed of your car? _____ mph Approximate speed of other car? ____ mph
Were you knocked unconscious? Yes No If yes, how long? _____
Were you taken to the Emergency Room? Yes No Were police notified? Yes No

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

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?

_____
_____

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

_____

Do you have any congenital (from birth) factors, which relate to this case? Yes No If yes, please describe:

_____

Have you ever been involved in an accident before? Yes No If yes, please describe, including date(s) and types of accidents, as well as injury(s) received

_____

Where were you taken after the accident? _____
Were you hospitalized? Yes No If yes, name of hospital: _____
Length of stay: _____
What type of treatment did you receive? _____
Were X-rays taken? Yes No

Since the injury occurred, are your symptoms: Improving Getting Worse Same

CHECK THE SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT:

__ Headache	__ Irritability	__ Sleeping Problems	__ Depression
__ Neck Pain	__ Chest Pain	__ Shortness of Breath	__ Ears Ringing
__ Neck Stiff	__ Dizziness	__ Numbness in Toes	__ Feet Cold
__ Tension	__ Fatigue	__ Numbness in Fingers	__ Loss of Memory
__ Back Pain	__ Nervousness	__ Pins & Needles in Arm	__ Loss of Balance
__ Back Stiff	__ Loss of Motion	__ Pins & Needles in Legs	__ Lights Bother Eyes

Symptoms other than above: _____

Have you lost time from work due to accident? Yes No Type of work: _____

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

_____
_____

Other pertinent information:

_____

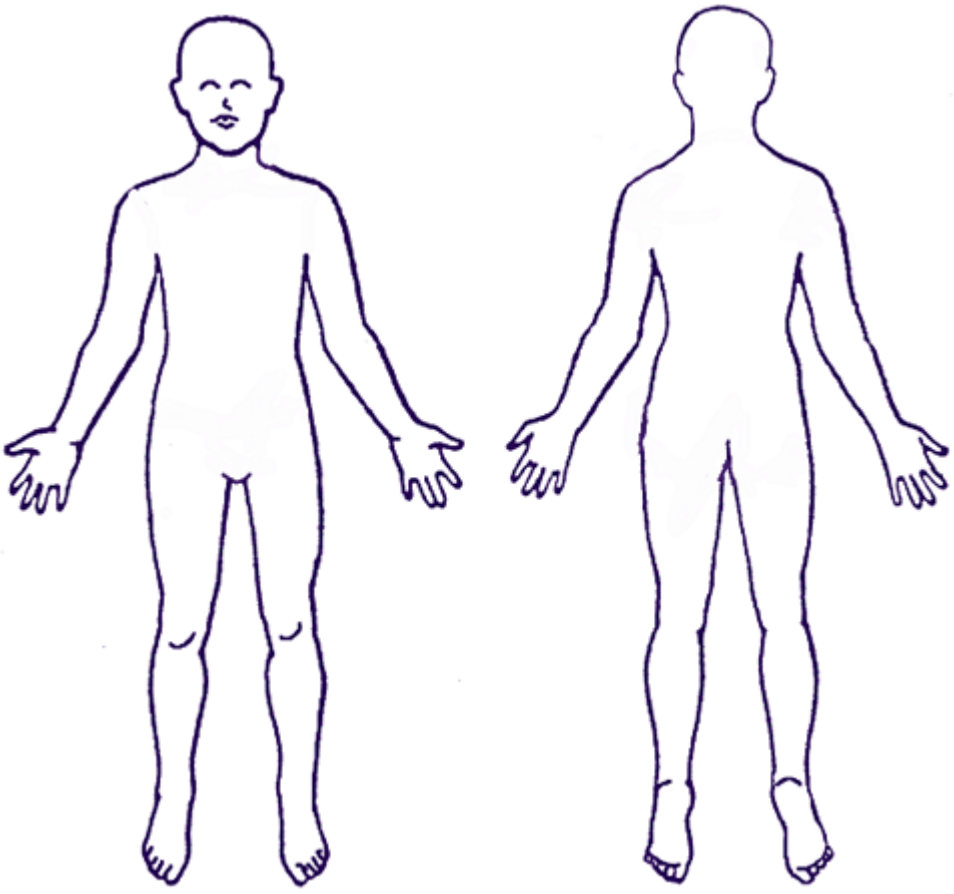
PAIN DIAGRAM

Patient Name: _____ **Date:** _____

Please complete the following "Pain Diagram" by using letters at the left to indicate on the diagram your areas of pain:

Pain (P)
Tingling (T)
Numbness (N)
Burning (B)
Stiffness (S)

Front **Back**



Patient signature: _____ **Date:** _____