PERSONAL INJURY QUESTIONNAIRE
Information About You:

YOUR E-MAIL ADDRESS: ____________________

Name ____________________ Phone __________
Address __________ City __________ State ______ Zip ______
Age ______ Birthdate __________ Sex ( ) M ( ) F S/S # __________
Employer's Name __________ Employer's Address __________
Your Ins. Co. __________ POLICY# ______ Agent's Name __________
Name on Policy (if other than self) __________ Policy # __________
Responsible Party's Name ____________________
Address __________ City __________ State ______ Zip ______
Policy Holder's Name ____________________

INFORMATION ABOUT YOUR ATTORNEY

Name __________ Phone __________ Fax: __________
Address __________ City __________ State ______ Zip ______
Were there any Witnesses? ( ) Yes ( ) No Names __________

INFORMATION ABOUT YOUR ACCIDENT

1. Date of Accident __________ Time of Day __________
2. Were You: ( ) Driver ( ) Passenger ( ) Front Seat ( ) Back Seat
3. Number of people in your vehicle? ______ Were you wearing seat belts? (Yes) (No)
4. What direction were you headed? ( ) North ( ) East ( ) South ( ) West
5. What direction was the other vehicle headed? ( ) North ( ) East ( ) South ( ) West
   on (name of street) ____________________
6. Were you struck from: ( ) Behind ( ) Front ( ) Left side ( ) Right side
7. Approximate speed of your car ______ mph. Other car ______ mph
8. Were you knocked unconscious? ( ) Yes ( ) No If yes, for how long?
9. Were police notified? ( ) Yes ( ) No
10. In your own words, please describe the accident: ____________________

____

____

11. Did you have any physical complaints immediately before this accident? ( ) Yes ( ) No
If yes, describe: ____________________

____

____

12. Please describe how you felt:
    a. DURING the accident: ____________________
    b. IMMEDIATELY AFTER the accident: ____________________
    c. LATER THAT DAY: ____________________
    d. THE NEXT DAY: ____________________

13. What are your PRESENT complaints and symptoms?

____

____

14. Do you have any congenital (from birth) factors which relate to this problem?

____

____

15. Do you have any previous illnesses which relate to this case? ( ) Yes ( ) No
If yes, please describe: ______________________________

____

16. Describe accidents in the past 10 years with injuries to the same body parts as your recent accident:
If yes, please describe, including date(s) and type(s) of accidents as well as injuries received:

____

17. Where were you taken after your current accident?

18. Have you been treated by another doctor since the accident? ( ) Yes ( ) No
If yes, names: ______________________________

19. Since this injury occurred, are your symptoms ( ) Improving ( ) Getting Worse ( ) Same

20. CHECK SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT:

( ) HEADACHE	( ) IRRITABILITY	( ) NUMBNESS-TOES	( ) FACE FLUSHED	( ) FEET COLD
( ) NECK PAIN	( ) CHEST PAIN	( ) SHORTNESS-BREATH	( ) BUZZING IN EARS	( ) HANDS COLD
( ) NECK STIFF	( ) DIZZINESS	( ) FATIGUE	( ) LOSS OF BALANCE	( ) STOMACH UPSET
( ) SLEEPING PROBLEM	( ) HEAD IS HEAVY	( ) DEPRESSION	( ) FAINTING	( ) CONSTIPATION
( ) BACK PAIN	( ) PINS/NEEDLES ARMS	( ) LIGHT SENSITIVE EYES	( ) LOSS OF SMELL	( ) COLD SWEATS
( ) NERVOUSNESS	( ) PINS/NEEDLES LEGS	( ) LOSS OF MEMORY	( ) LOSS OF TASTE	( ) FEVER
( ) TENSION	( ) NUMBNESS-FINGER	( ) EARS RING	( ) DIARRHEA	( ) ________

Symptoms other than above ______________________________

21. Have you lost time from work as a result of this accident? ( ) Yes ( ) No

a. Last day worked: ______________________________
b. Type of employment: ______________________________
c. Present Salary: ______________________________
d. Are you being compensated for time lost from work? ( )Yes ( ) No
If yes, type of compensation you are receiving: ______________________________

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

____

23. Other pertinent information: ______________________________

____

____

______________________________ Date

______________________________ Patient's Signature

FOCUS CHIROPRACTIC CENTER

451 S. Brand Blvd. #203
San Fernando, Ca 91340
(818) 838-4900 Fax: (818) 838-4901

916 West Burbank Blvd #L
Burbank, Ca 91506
(818) 842-7700 Fax (818) 842-7001

PATIENT'S NAME: ______________________________ **TODAY'S DATE:** ______________

PERSONAL INJURY FORM

YOUR MEDICAL HISTORY

Do you suffer from?

High Blood Pressure _____ Diabetes _____
Arthritis _____ Tuberculosis _____
Ulcers _____ Kidney/Liver Disease _____
Epilepsy _____ Heart Disease _____
Others ____
____

Previous Surgeries or Hospitalizations:____
____

ALLERGIES (Please include all to drugs/food/etc.)____

YOUR HABITS

Do You: Drink Coffee _____ Drink Alcohol _____ Use Tobacco _____ Use Illicit Drugs _____

How much of each? _____ _____ _____ _____

Do You: Use any prescribed medication? ____ Names:________________________________

Did/Do You: Take any medication **after** this accident? ___ Names: ________________________

Do you Exercise Regularly? Yes / No How Often? ________________________

Have you stopped your exercise habits since the accident?________________________

FAMILY HEALTH PROBLEMS (please, only major medical illnesses such as diabetes, cancer, HBP, etc.)

Mother's Health History:____

Father's Health History:____

Other Blood Relative:____

YOU ARE: **MARRIED** **SINGLE** **YOU HAVE:** **CHILD(REN)**

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YOUR INSURANCE INFORMATION (Please, fill out this form completely)

NAME: ____

Last Name First Name Middle

ATTORNEY REPRESENTATION? YES / NO **Attorney's Name:** ____________________

ATTORNEY'S ADDRESS: ____

____

ATTORNEY'S PHONE #: ____

YOUR MEDICAL COVERAGE: ____

POLICY #: ____

INSURANCE COMPANY'S ADDRESS: ____

YOUR AUTO INSURANCE: ____

POLICY #: ____________________ COMPANY PHONE #: (______) ____________________

OTHER PARTY'S INSURANCE COMPANY INFORMATION:

INSURANCE COMPANY: ____

INSURED'S NAME ____

INSURED'S ADDRESS: ____

INSURED'S PHONE #: (______) ____________________ (______) ____________________

POLICY/CLAIM #: ____________________ COMPANY PHONE #: (______) ____________________

____________________ ____________________

Date Patient's Signature