Koehler Chiropractic Offices

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(815-939-4900)

Date ____________

PERSONAL INJURY QUESTIONNAIRE

Name____________ Date of Injury____________ Phone____________
Address____________ City____________ State ________ Zip________
Employer's Name____________ Employer's Address____________
Your Ins. Co.____________ Policy #____________ Agent's Name____________
Driver/Other Vehicle____________ Ins Co.____________ Policy #____________
Have you retained an attorney? ( ) Yes ( ) No Name____________
Were there any witnesses? ( ) Yes ( ) No Name(s)____________

NATURE OF ACCIDENT:

1. Date of Accident ____________ Time of Day ____________
2. Were you: ( ) Driver ( ) Front Seat Passenger ( ) Left Rear Seat ( ) Right Rear Seat
3. Number of people in your vehicle? ____________ Other Vehicle? ____________
4. What direction were you headed? ( ) North ( ) East ( ) South ( ) West
   on (name of street) ____________
5. What direction was other vehicle headed? ( ) North ( ) East ( ) South ( ) West
   on (name of street) ____________
6. Were you struck from: ( ) Behind ( ) Front ( ) Left Side ( ) Right Side
7. Were you knocked unconscious? ( ) Yes ( ) No If yes, for how long?____________
8. Were police notified? ( ) Yes ( ) No
9. In your own words, please describe accident: ____________
10. Were you wearing a seat belt? ( ) Yes ( ) No If so, what type? ( ) Lap ( ) Shoulder
11. Did your seat have a head restraint (headrest)? ( ) Yes ( ) No
    If so, what was the position of the head restraint? ( ) Low ( ) Midposition ( ) High
12. Did your vehicle strike the other vehicle? ( ) Yes ( ) No
13. Was your vehicle struck by the other vehicle? ( ) Yes ( ) No
14. What was the approximate speed at the time of impact? Your vehicle________ mph Other vehicle________ mph
15. What were the road conditions? ( ) Dry ( ) Wet ( ) Icy
16. At the time of impact were you: ( ) Looking straight ahead ( ) Looking to the right ( ) Looking to the left
    ( ) Looking down ( ) Looking up
17. Were both hands on the steering wheel? ( ) Yes ( ) No If no, which hand? ( ) Left ( ) Right
18. Was your foot on the brake? ( ) Yes ( ) No If so, which foot? ( ) Left ( ) Right
19. Were you braced at the time of impact? ( ) Yes ( ) No
20. Did you strike anything at the time of impact? ( ) Yes ( ) No
    If so, please specify ( ) Seatbelt restraints ( ) Steering wheel ( ) Dashboard ( ) Windshield ( ) Side door
    ( ) Side window ( ) Other ____________
    Please state part of body: ( ) Chest ( ) Head ( ) Chin ( ) Face ( ) Rt/Lt knee ( ) Rt/ Lt shoulder
    ( ) Rt/Lt hand ( ) Other ____________

21. Please describe how you felt:

a DURING the accident: ______

b. IMMEDIATELY AFTER the accident: ( ) Conscious ( ) Dazed ( ) Unconscious

c. LATER THAT DAY: ______

d. THE NEXT DAY: ______

22. What are your PRESENT complaints and symptoms? ______

23. Do you have any congenital (from birth) factors which relate to this problem? ( ) Yes ( ) No

If yes, please describe: ______

24. Do you have any previous illnesses which relate to this case? ( ) Yes ( ) No

If yes, please describe: ______

25. Have you ever been involved in an accident before? ( ) Yes ( ) No

If yes, please describe, including date(s) and type(s) of accidents, as well as injury(ies) received. ______

26. Where were you taken after the accident? ______

27A. Have you been treated by another doctor since the accident? ( ) Yes ( ) No

If yes, please list doctor's name and address: ______

What type of treatment did you receive? ______

27B. Did you go to the hospital? ( ) Yes ( ) No

If so, when? ( ) At time of accident ( ) Next day ( ) Other

27C. How did you get to the hospital? ( ) Ambulance ( ) Private transportation

If by ambulance, did the ambulance attendants place you in a: ( ) Neck brace ( ) Back brace

( ) Other ______

27D. If you went to the hospital, please answer the following:

Name of Hospital ______

Name of Doctor ______

Diagnosis ______

Treatment received ______

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

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

If yes, please complete this question.

a. Last Day Worked: ______

b. Type of Employment: ______

c. Are you being compensated for time lost from work? ( ) Yes ( ) No

If yes, please state type of compensation you are receiving: ______

30. Do you notice any activity restrictions as a result of this injury? ( ) Yes ( ) No.

If yes, please describe, in detail: ______

31. Requested medical records from:

1. ______

2. ______

3. ______

Date ______ Signature ______