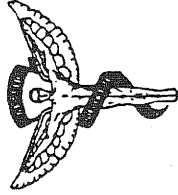


Koehler Chiropractic Offices

232 NORTH MAIN
BOURBONNAIS, ILLINOIS 60914
(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 _____