PERSONAL INJURY NEW PATIENT QUESTIONNAIRE

Community Chiropractic Center
Poway CA

BASIC/REQUIRED CONTACT INFORMATION: DATE: ____________________

Name: ______________________________ Social Security #: ____________ Phone: ( ) ____________

Address: ______________________________ City: ________________ State: ___ Zip Code: __________

E-mail: ____ Birthdate: ________________

Height: ______ Weight: ______ Age: _____ Whom may we thank for referring you? ________________

ATTORNEY INFORMATION: ❑ Not Yet Selected ❑ Information Below

Name: ____ Phone: ( ) __________

Address: ____________________________ City: ________________ State: ___ Zip Code: ________

NATURE OF 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
   Name of Street: _______________ City:_________ Make/Model of your vehicle: ______________ Year: _____
5. What direction was the other vehicle headed? ❑ North ❑ East ❑ South ❑ West
   Name of Street: _______________ City:_________ Make/Model of other vehicle: ______________ Year: _____
6. Where you struck from: ❑ Behind ❑ Front ❑ Left Side ❑ Right Side ❑ Multiple Cars Involved
7. Approximate speed of your car: _______ mph Approximate speed of other vehicle: _______ mph
8. Were you knocked unconscious? ❑ Yes ❑ No If yes, for how long? ______________
9. Was the impact ❑ Unexpected ❑ Expected ❑ Expected and braced for impact
10. Did airbags deploy? ❑ Yes ❑ No
11. Were the police notified? ❑ Yes ❑ No
12. In your own words, please describe the accident: ____
    ____
    ____
13. Did you have any physical/health complaints BEFORE THE ACCIDENT? ❑ No, I was in excellent health ❑ Yes
    If yes, please describe in detail: ____
    ____
    ____
14. Please describe how you felt and any pain since the accident:
    a. IMMEDIATELY AFTER the accident: ____
    b. LATER THAT DAY: ____
    c. THE NEXT DAY/DAYS LATER: ____
15. Regarding your most recent accident, did EMS, Fire Department or Others evaluate you at the scene? ❑ Yes ❑ No
16. Were you taken by ambulance from the scene of the accident? ❑ Yes ❑ No
17. Have you been treated by another doctor since the accident? ❑ Yes ❑ No If yes, please list their name and facility information: ____
18. Since the injury occurred, are your symptoms: ❑ Improving ❑ Getting Worse ❑ About the same
19. Please indicate your symptoms on the separate form in this packet titled “Initial Symptoms”.

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18. Have you ever before been involved in an accident with similar symptoms? ❑ Yes ❑ No
    If yes, please list areas of complaint that were involved:
    Area # 1:____ 100% Recovery ❑ Yes ❑ No
    Area # 2:____ 100% Recovery ❑ Yes ❑ No
19. Do you have congenital (from birth) factors that relate to any of your current symptoms? ❑ Yes ❑ No Please describe:
    ____
20. Do you have any previous illnesses that relate to this case? ❑ Yes ❑ No If yes, please list:
    ____
21. Have you lost time from work as a result of this most recent accident? ❑ Yes ❑ No If yes, please complete below:
    A. Last Day Worked: ________________ B. Type of Employment: ______________________________

Visual Analog Pain Scale

- **0 No Pain**
- **1 Minimal Pain (Annoyance)**
- **2 Constant Minimal to Intermittent Slight Pain**
- **3 Constant Slight Pain (Some Handicap)**
- **4 Constant Slight to Intermittent Moderate Pain**
- **5 Constant Slight to Frequent Moderate Pain**
- **6 Intermittent Moderate Pain (Marked Handicap)**
- **7 Frequent Moderate Pain**
- **8 Constant Moderate Pain**
- **9 Constant Moderate to Intermittent Severe Pain**
- **10 Constant Severe Pain (Incapacitated)**

SEVERITY OF PAIN

1

List regions of pain
(1=least; 10 = greatest)

LEVEL OF SEVERITY BY REGION

Region											
Head	0	1	2	3	4	5	6	7	8	9	10
Neck	0	1	2	3	4	5	6	7	8	9	10
Arms	0	1	2	3	4	5	6	7	8	9	10
Mid Back	0	1	2	3	4	5	6	7	8	9	10
Low Back	0	1	2	3	4	5	6	7	8	9	10
Hips	0	1	2	3	4	5	6	7	8	9	10
Legs	0	1	2	3	4	5	6	7	8	9	10

2

MARK PAIN REGION

Burning	Stabbing	Sharp	Constant	Other
+++	OOO	- - -	|||	XXX

Left Right

Right Left

21. Other pertinent information: ____
____

Patient Name: ______________________ Patient Signature: ______________________

Doctor Review: ______________________ Date: ______________

Mark Burdette, DC Nicolas LaHood, DC Richard Doss, DC