

PERSONAL INJURY NEW PATIENT QUESTIONNAIRE



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

SEVERITY OF PAIN

1

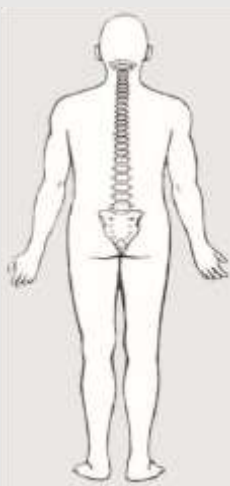
List regions of pain
(1=least; 10 = greatest)

LEVEL OF SEVERITY BY 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

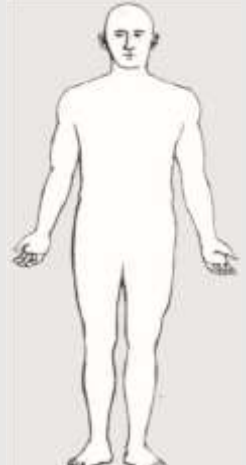
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MARK PAIN REGION

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



Right Left

21. Other pertinent information : _____

Patient Name: _____	Patient Signature: _____
Doctor Review: _____	Date: _____
Mark Burdette, DC Nicolas LaHood, DC Richard Doss, DC	