Core Chiropractic & Wellness Center
116 N Dodge Street, Unit 2
Burlington, WI 53105
p. 262.767.0500
f. 262.767.1534

Personal Injury/Accident Questionnaire

Full Name: _____ Date of Injury: _____ Time: _____
LAST FIRST M.I.

Where did the accident happen? _____

Describe the accident in your own words_____

_____

_____

What was your position in the vehicle? ☐ Driver ☐ Passenger If passenger, sitting: ☐ Front ☐ Right Rear ☐ Left Rear

Did your vehicle strike the other vehicle? ☐ Yes ☐ No Was your vehicle struck by the other vehicle? ☐ Yes ☐ No

The impact was from the: ☐ Front ☐ Right Side ☐ Left Side ☐ Rear

At the time of impact were you looking: ☐ Straight ahead? ☐ Right? ☐ Left?

Were both hands on the steering wheel? ☐ Yes ☐ No Was your foot on the brake? ☐ Yes ☐ No

Were you braced for impact? ☐ Yes ☐ No Were you wearing your seat belt? ☐ Yes ☐ No

Where in the vehicle were you after the accident? _____

Did you strike anything in the vehicle at the time of impact?

Chest	☐ Steering Wheel	☐ Dashboard	☐ Windshield	☐ Side Door	☐ Armrests	☐ Side Window	☐ Other _____
Chin	☐ Steering Wheel	☐ Dashboard	☐ Windshield	☐ Side Door	☐ Armrests	☐ Side Window	☐ Other _____
Knee	☐ Steering Wheel	☐ Dashboard	☐ Windshield	☐ Side Door	☐ Armrests	☐ Side Window	☐ Other _____
Shoulder	☐ Steering Wheel	☐ Dashboard	☐ Windshield	☐ Side Door	☐ Armrests	☐ Side Window	☐ Other _____
Hand	☐ Steering Wheel	☐ Dashboard	☐ Windshield	☐ Side Door	☐ Armrests	☐ Side Window	☐ Other _____
Head	☐ Steering Wheel	☐ Dashboard	☐ Windshield	☐ Side Door	☐ Armrests	☐ Side Window	☐ Other _____

Immediately following the accident, how did you feel? _____

_____

Were you unconscious? ☐ Yes ☐ No In a daze? ☐ Yes ☐ No

Did you go to the hospital? ☐ Yes ☐ No If so, when? ☐ At time of accident ☐ Next day ☐ Other _____

How did you get to the hospital? ☐ Ambulance ☐ Private Transportation ☐ N/A

Did the ambulance place you in a: ☐ Neck Collar ☐ Splints ☐ Brace ☐ None ☐ Other _____

Name of Hospital _____Attended by Dr. _____

Were x-rays done at the hospital? ☐ Yes ☐ No If so, what was the diagnosis? _____

Were you admitted to the hospital? ☐ Yes ☐ No How long did you stay? _____

What treatment was rendered? _____

What recommendations were made? ☐ See own doctor ☐ Chiropractic ☐ Physical Therapy ☐ Orthopedic Specialist ☐ Other

Have you seen any other doctor as a result of this accident? ☐ Yes ☐ No Doctor's Name: _____

Are your symptoms ☐ Constant ☐ On & Off ☐ Sharp ☐ Dull ☐ Other _____

Do any of the following make your symptoms worse? (Select one or more)

☐ Rising from a chair ☐ Bowel Movements ☐ Coughing ☐ Straining ☐ Sneezing ☐ Moving in Bed ☐ Stretching ☐ Twisting

Do you have numbness or tingling in any of the following areas? (check all that apply)

☐ Arms ☐ Hands ☐ Fingers ☐ Legs ☐ Feet ☐ Toes ☐ Other _____

Do you experience any cramps in your arms or legs? ☐ Yes ☐ No Any change in bowel movements? ☐ Yes ☐ No

Do any of the following make your symptoms better? (check all that apply)

☐ Heating Pad ☐ Hot bath ☐ Shower ☐ Ice Pack ☐ Brace ☐ Moving Around ☐ Firm Mattress ☐ Resting

Most comfortable position?

☐ Sitting ☐ Standing ☐ Lying on Stomach ☐ Lying on Back ☐ Lying on Right ☐ Lying on Left ☐ Other _____

Have you lost any time from work due to this accident? ☐ Yes ☐ No If yes, give dates of time lost _____
Totally disabled from _____ to _____ Partially disabled from _____ to _____

BEFORE YOUR ACCIDENT, estimate your total lifting effort ability:
Maximum Weight _____ Average Weight _____ How far could you carry _____ For how long _____

Was lifting done at work? ☐ Yes ☐ No At home? ☐ Yes ☐ No How often can you carry this amount of weight? _____

AFTER YOUR ACCIDENT, describe your total lifting ability WITHOUT EXPERIENCING PAIN, DISCOMFORT OR RESTRICTION OF MOTION:
Maximum Weight _____ Average Weight _____ How far could you carry _____ For how long _____

Did you experience this pain, discomfort or restriction of motion before your accident? ☐ Yes ☐ No

Are you now limited in your total lifting ability in a body position that you were previously not? ☐ Yes ☐ No
Specify position _____

What symptoms does lifting produce? _____How long do symptoms last? _____

What positions can you work in with a MINIMUM DEMAND of physical effort? _____

With minimum demand of physical effort, what positions can you work in PART-TIME and for how long?

Standing _____ Sitting _____ Walking _____

With minimum demand of physical effort, can you work in a sitting position with some degree of waling or standing activity?
☐ Yes ☐ No Explain _____

Do you feel you cannot perform any physical work activity? ☐ Yes ☐ No Any mental work activity? ☐ Yes ☐ No

Relate your BEFORE injury capacity (mark "B") to your AFTER injury capacity (mark "A") for performing activities:

Walking	Normal _____	Limited _____	Difficult_____	Pain_____
Standing	Normal _____	Limited _____	Difficult_____	Pain_____
Bending	Normal _____	Limited _____	Difficult_____	Pain_____
Stooping	Normal _____	Limited _____	Difficult_____	Pain_____
Lifting	Normal _____	Limited _____	Difficult_____	Pain_____
Pushing	Normal _____	Limited _____	Difficult_____	Pain_____
Pulling	Normal _____	Limited _____	Difficult_____	Pain_____
Climbing	Normal _____	Limited _____	Difficult_____	Pain_____
Reaching	Normal _____	Limited _____	Difficult_____	Pain_____
Gripping	Normal _____	Limited _____	Difficult_____	Pain_____
Kneeling	Normal _____	Limited _____	Difficult_____	Pain_____
Balance	Normal _____	Limited _____	Difficult_____	Pain_____
Fatigue	Normal _____	Limited _____	Difficult_____	Pain_____

Generally speaking, is your inability to perform these functions due to: ☐ Pain ☐ Weakness ☐ Structural Limitations ☐ Nerves

Do you have normal sexual function? ☐ Yes ☐ No

Are you able to take personal care of yourself such as dressing, bathing, etc.? ☐ Yes ☐ No

Or do you require personal assistance? ☐ Yes ☐ No

Do you feel your present condition is ☐ Permanent ☐ Temporary

Insurance Information

Auto Insurance Company _____ Claim # _____

Insurance Adjuster's Direct Contact: Phone _____ Email _____

Attorney _____ Phone _____ Email _____

Is the auto policy above YOUR auto policy? ☐ Yes ☐ No

If no, please list YOUR Auto Insurance Company _____ Phone _____.
Sometimes we are required to submit directly to your personal auto policy even if you were not at fault.

Signature_____ Date _____