SIGNAL HILL CHIROPRACTIC CENTER, INC.
CONFIDENTIAL PATIENT HISTORY **Date** _____
PERSONAL INJURY QUESTIONNAIRE

Name_____ **Home Phone ( )**_____
Address_____ **City**_____ **State**_____ **Zip**_____
Age_____ **Birth Date**_____ **Social Security #**_____
Marital Status: M S W D **How Many Children**_____
Occupation_____ **Employer**_____
Address_____ **Work Phone ( )**_____
Name of Spouse_____ **Spouse SS#**_____
Spouse's Employer_____ **Work Phone ( )**_____
Address_____
Name of Emergency Contact_____ **Phone ( )**_____
(Nearest relative not living in your home.)
How do you prefer to be addressed?_____
Referred By:_____
FAMILY DR./PRIMARY CARE PHYSICIAN:_____
We will be keeping your family doctor or referring doctor informed regarding your care at this office by sending them office notes.
Please specify name and address. _____
_____
_____
Your Car Insurance Company_____**Phone#:**_____
Agent_____
Name on Policy (if other than self)_____
Policy #:_____
Your Major Medical Insurance Company_____
ID#:_____
Responsible Party's Insurance Company_____ **Phone #**_____
Address_____ **City**_____ **State** ____ **Zip**_____
Individual Responsible_____ **Policy #:**_____

ATTORNEY
Name_____ **Phone # ( )**_____
Address_____ **City**_____ **State**_____ **Zip**_____
Were there any witnesses? ( ) Yes ( ) No
Name (s)_____

NATURE OF ACCIDENT
1. **Date of Accident**_____ **Time of Day** _____
2. **What street were you traveling on?**_____
3. **What street was the other vehicle traveling on?**_____
4. **Approximate speed of you car** _____ **MPH** **Other Car**_____ **MPH**
5. **Were police notified? ( ) Yes ( ) No**
6. **In your own words, please describe the accident:**_____
_____
_____
7. **Where were you taken after the accident?**_____

Present Complaint: _____
_____

When did your problem begin: Specific date if possible?_____

How did your problem begin? ( ) Trauma ( ) Repeated Motion ( ) Other
Explain:_____

In the past have you had anything similar to this? ( ) Yes ( ) No
Please explain:_____

For your present complaint have you seen any other doctors? ( ) Yes ( ) No
_____

How intense is the pain? ( ) Mild/dull ( ) Moderate ( ) Severe/Excrutiating/Agonizing

Please describe the character of your current pain. (You may check one or more answers.)
( ) Sharp/stabbing ( ) Burning ( ) Shooting ( ) Aches ( ) Soreness ( ) Weakness
( ) Throbbing/Gnawing ( ) Numbness ( ) Dull ( ) Gripping/Constricting ( ) Other_____

How often are the complaints present? ( ) Constant/100% of the time ( ) Frequent/75%
( ) Intermittent/50% ( ) Occasional/25%

Is the pain: ( ) Increasing ( ) Decreasing ( ) Not Changing

Pain is aggravated by: ( ) Walking ( ) Sitting ( ) Standing ( ) Riding in Car ( ) Lifting
( ) Bending ( )Stretching ( )Twisting ( ) Other_____

Are your complaints affecting your ability to work or be active? ( ) No Effect ( ) Some Physical Restrictions ( ) Unable to perform regular duties

Are your complaints affecting your ability to sleep? ( ) Yes ( ) No

Have you missed any days of work or school? ( ) Yes ( ) No
Dates missed:_____

Have you <u>ever</u> broken any bones? ( ) Yes ( ) No _____

Have you been in the hospital or had surgery for your present complaint?
( ) Yes ( ) No_____

Have you ever been in the hospital or had surgery for any other reason? ( ) Yes ( ) No
Please explain _____
_____

What medications or Drugs are you taking?
Nerve Pills_____ Pain Killers_____ Muscle Relaxers _____ Blood Pressure Medication_____
Insulin_____ Birth Control Pill_____ Tranquilizers_____ Diet Pills_____ Anti-Inflammatory_____
Any non-prescription medication?
Tylenol_____ Ibuprofen_____ Aspirin_____ Other_____

Do you smoke? ( ) Yes ( ) No

What is you exercise routine?_____
_____

Other Health Concerns:_____