Ybor City CHIROPRACTIC

1623 East 4th Avenue
Tampa, Florida 33605
813-248-2900

Personal Injury Questionnaire

Name: _____

Address: _____

Sex: ☐ M ☐ F Age: _____ Birthdate: _____ Patient SSN: _____

Insurance Company: _____ Claim #: _____

Name on policy (if other than self): _____

Responsible party

Name: _____

Address: _____

Attorney

Name: _____ Phone: _____

Address: _____

Nature of Accident

Date of accident: _____ Time of Day: _____

What was the weather condition? _____

You were the ☐ *Driver* ☐ *Passenger* of ☐ *own car* ☐ *another's car* in the ☐ *front seat* ☐ *back seat*

Number of people in the car: _____ Were you wearing seatbelts? ☐ Yes ☐ No

Which direction were you heading? ☐ North ☐ South ☐ East ☐ West

on (name of street) _____

Did your car strike the other car? ☐ Yes ☐ No

Did the other car strike your car? ☐ Yes ☐ No

Car was struck from the ☐ Back ☐ Front ☐ Left side ☐ Right side

Approximate speed of your car _____ mph, the other car _____ mph.

Did the impact cause you to lose consciousness? ☐ Yes ☐ No

In your own words, briefly describe the accident. _____

_____

_____

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Where were you taken after this accident? _____

Have you been treated by another doctor since the accident? ☐ Yes ☐ No

If so, who? _____

Since the injury, are your symptoms ☐ Improving ☐ Worsening ☐ Same

Have you missed work as a result of this accident? ☐ Yes ☐ No

Last day worked _____

Occupation _____

Are you being compensated for time lost from work? ☐ Yes ☐ No

By whom? _____

Do you notice any daily activity restrictions as a result of this accident? ☐ Yes ☐ No

If so, please describe: _____

_____

_____

_____

Did you have physical complaint(s) BEFORE the accident? ☐ Yes ☐ No

If so, please describe: _____

How did you feel:

During the accident _____

Immediately after _____

Later that day _____

The next day _____

What are your current complaints and symptoms: _____

_____

Do you have any previous illness which relate to this case? ☐ Yes ☐ No

If so, please describe: _____

Please describe any previous accident(s) you have been involved in, include dates and any injuries received. _____

_____

_____

Patient Signature: _____ Date: _____