Abshire Chiropractic Personal Injury Questionnaire

Name:_____ Date of Birth:_____
Date of Accident:_____ Time: _____ ○am / ◉pm City/State Occurred: _____
Street Location: _____
Type of accident (select & continue to appropriate section) ◉Auto Collision ○On the job injury ○Other_____

INSURANCE COMPANIES INVOLVED

My Company: _____
Company Responsible: _____
Have you been contacted by an insurance adjuster or company representative? Yes ◉ No ○
Do you have an attorney advising you in regards to this claim? Yes ◉ No ○
Did the attorney advise you in care at our office? Yes ◉ No ○
Attorney's Name: _____ Phone: _____
Address: _____ City/State: _____

ON THE JOB INJURY

If On the Job Injury, please describe the circumstances: _____
_____
_____
Was the injury reported to your foreman or employer? ○Yes ○No
Did they recommend our office for care? ○Yes ○No
Did you know the accident was coming? ○Yes ○No
Did you lose consciousness during the accident? ○Yes ○No
Did you go to a hospital? ○Yes ○No (If no skip to signature)
Were you hospitalized over night? ○Yes ○No
Did you receive any stitches for any cuts at the hospital? ○Yes ○No
Were Xrays taken at the hospital? ○Yes ○No If yes, which areas? _____
What you were prescribed at the hospital: ☐Pain Medicine ☐Muscle Relaxors ☐Neck Brace
What was the name of the hospital? _____
How did you get to hospital? _____
Signature: _____ **Date:**_____

AUTO COLLISION

What direction were you traveling in? _____
How many vehicles were involved? _____
What direction were you struck from? (check all that apply) ☐ Front ☐ Behind ☐ Left Side ☐ Right Side ☐ Auto was parked
As a result of the accident were you issued a ticket? ○Yes ○No
The driver of the other car? ○Yes ○No
The driver of the car you were in? ○Yes ○No
Did your car strike the other(s) involved? ○Yes ○No
OR did the other car strike yours? ○Yes ○No ○Undetermined
Did your vehicle hit anything after the accident? ○Yes ○No
If yes please describe: _____
Where were you sitting during the accident? ☐ Driver ☐ Front Passenger ☐ Rear Passenger Left ☐ Rear Passenger Middle ☐ Rear Passenger Right
Did you know the accident was coming? ○Yes ○No
Did you lose consciousness during the accident? ○Yes ○No
Did you have your seatbelt on during the accident? ○Yes ○No
Did you go to a hospital? ○Yes ○No (If no skip to signature)
Were you hospitalized over night? ○Yes ○No
Did you receive any stitches for any cuts at the hospital? ○Yes ○No
Were Xrays taken at the hospital? ○Yes ○No If yes, which areas? _____
What you were prescribed at the hospital: ☐Pain Medicine ☐Muscle Relaxors ☐Neck Brace
What was the name of the hospital? _____
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Signature: _____ **Date:**_____