(Auto) / (personal injury)/ (slip & fall) Questionnaire

Name: _____ Birth Date: _____ Age: _____

Street address: _____ City: _____ State _____ Zip _____

Phone Number: _____ Email Address: _____@_____. Com/__Net/ Org.

You're Auto Insurance Company: _____

Policy #_____ Claim#_____

Adjusters Name _____ Adjusters phone #_____

Have you retained an attorney? Yes____, No_____

If so name _____ Phone number _____

PERSONAL INJURY HISTORY

Date of injury_____ Time _____ A.M. /PM.

Where did this injury occur? _____

1. How did your injury happen? □ Slip & Fall □ Sports Injury □Tripped & Fell

□ Pedestrian hit by a car □Other _____

2. Were other people in your car? □ Yes □No If yes, how many _____

3. In your own words describe exactly how it happened and what caused it?
"_____
_____"

4. How did you feel immediately after your injury/accident ? _____

5. Did your pain begin gradually? □Yes □No Immediately? □Yes □No

6. Is your pain? □Getting better □Getting worse

7. Have you had this or a similar condition before? □Yes □No If yes, when? _____

8. Were you unconscious? □Yes □No If yes, how long? _____ did you have a seatbelt on? □Yes □No did air bags deploy □Yes □No

9. Did you receive medical aid at the time of your injury/accident? □Yes □No if yes, by whom?
_____

10. Where did you go right after your injury/accident? □ Hospital Emergency □ treatment center □ Home □ Family physician

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11. How did you get there? **□Ambulance □ Drove myself □ someone drove me**

12. If hospitalized how long? _____Name of hospital_____

13. Have you been treated by any doctor or therapist for this PRESENT injury? □ Yes □No

If yes, Name _____

14. Prescriptions received: **□Pain killer's □Muscle relaxants □ other _____**

15. CHECK ANY SYMPTOMS YOU HAVE NOTICED SINCE YOUR INJURY/ACCIDENT

□Headache □Irritability □Tension □Ears Ring □Neck Pain

□Chest Pain □Numbness in Toes □Vomiting □Cold Feet □Neck Stiff

□Dizziness □Shortness of Breath □Buzzing in Ears □Hands Cold □Sleeping Problems□ □Fatigue □Loss of Balance □Back Pain □Loss of Smell

□Nervousness □Pins & Needles in Legs □Pins & Needles in Arm

21. Have you lost any time off work as a result of this injury? □Yes □No

If yes Dates_____

Office Policies: If you are using group insurance**,** we are in network with many insurance companies **,** We accept assignment on these companies , which means we will bill the insurance company for you and wait for payment directly , you are responsible for any amount not paid by your insurance company (**deductibles, and co-payments**)

Consent to treat: I understand that no cures are promised (or) implied and any risks reguarding care will be explained to me upon request. I authorize Dr. Caldwell proceed with any necessary treatment I have read office policies and consent to treat information, and I agree with them by signing below:

_____ Date: _____

Signature of patient

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