SLOAN FAMILY CHIROPRACTIC, P.S.
911 5th Ave SE, Suite 202 Olympia, WA 98501
DAVID SLOAN, DC, DIBCN
HEATHER SLOAN, DC
(360)956-3900/fax (360)956-3903

## Personal Injury Questionnaire

Name_______________________________________________ Date_____________________

Address______________________________________ State______ Zip_________________

Birth date________________________ Sex___________ SSN___________________________

Phone (home) ______________________________ (work) _____________________________

Insurance Company_________________________ Claim #______________________________

Name on Policy (if other then self)___________________________ Policy #_________________

Attorney______________________________ Attorney Phone___________________________

Date of Accident_________________ Time of Accident______:______ AM or PM

In your own words, please describe how the accident occurred: __________________________

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

Road conditions at the time of the accident: Wet [ ] Dry [ ] Icy [ ] Other [ ]

Whose car were you in?___________________________________________________________

Make__________________________ Model_________________________ Year____________

Were you: [ ] Driver [ ] Passenger [ ] Front Seat [ ] Back Seat

What direction was the car traveling? [ ] North [ ] South [ ] East [ ] West

Street Name____________________________ Closest cross street________________________

City/Town___________________________________ State____________

Number of cars involved in the accident_______________ Number of persons_______________

Second Vehicle: Make_______________________ Model_______________ Year___________

Was your vehicle: [ ] Moving [ ]Stopped [ ] Turn left [ ] Turn right

**Following Impact**

Did you experience: [ ] Confusion [ ] Nausea [ ] Disorientation

[ ] Dizziness [ ] Blurred Vision [ ] Ringing in Ears

If you still have any of these symptoms please describe:___________________________________

_____________________________________________________________________________

Please describe how you felt:

a. DURING the accident:_____________________________________________________________

b. IMMEDIATELY AFTER the accident:_______________________________________________

c. LATER that day:_________________________________________________________

d. The NEXT day:____________________________________________________________

Where there any areas of bleeding on your body? Yes No (circle)

If yes, please describe:______________________________________________________________

Were there any bruises on your body? Yes No (circle)

If yes, please describe:______________________________________________________________

Were you able to get out of the car and walk? Yes No (circle)

If not, Why? ______________________________________________________________________

Could you move all your body parts? Yes No (circle)

If not, please describe:______________________________________________________________

Were you conscious at all times? Yes No (circle)

If not, how long were you unconscious for?_______________________________________________

Were there any complications?_________________________________________________________

**Hospital**

Did you go to a hospital? Yes No (circle)

If yes, name & location of hospital: ___________________________________________________

How did you get to the hospital?:_______________________________________________________

What parts of your body were examined?:_______________________________________________

What parts of your body were X-Rays taken (if any)?______________________________________

How did the hospital treat your injuries?_________________________________________________

_____________________________________________________________________________

How long did you stay at the hospital?__________________________________________________

If the vehicle was not moving, and you were the driver, was your foot on the brake at the time of impact? Yes No (circle)

If the vehicle was moving, what was the speed of your vehicle? ____________mph

Where was your vehicle struck? [ ] Rear [ ] Left Middle [ ]Right Front

[ ] Right Rear [ ] Front [ ] Left Front [ ] Left Rear [ ] Right Middle

What was the speed of vehicle #2? __________mph

Did you see the accident coming? Yes No (circle)

Was the trunk of your body (lower portion) facing straightforward at the time of the accident?

Yes No (circle) If not, what direction?___________________________

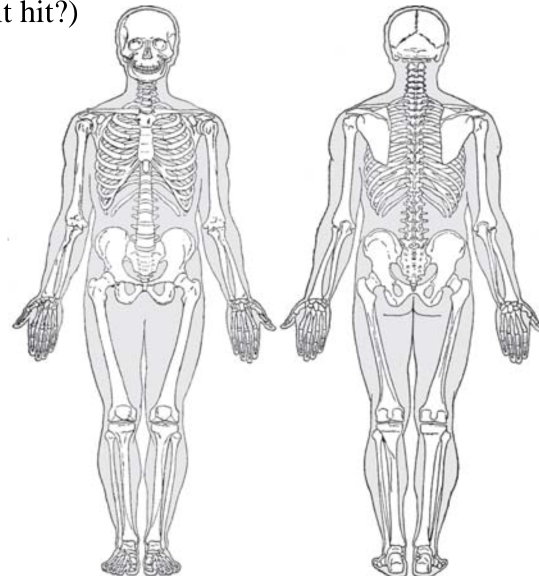
What direction were you looking at the time of impact?__________________________________

Were you wearing a seat belt? Yes No (circle) [ ] Shoulder [ ] Lap [ ] Both

**Upon Impact**

Did any parts of your body hit the inside of the vehicle? Yes No (circle)

(circle the region to the right and list where it hit?)



What direction was your body thrown? [ ] Forward [ ] Backward [ ] Right [ ] Left

Other:________________________________________________________________________

Did you receive an injury or bruise from the seatbelt? Yes No (circle)

If yes, please describe____________________________________________________________

Was an airbag deployed? [ ] Driver [ ] Passenger

**Police:**

Was a police report made? Yes No (circle)

**The Vehicle you were traveling in:**

How far is the headrest or seatback from the top of your head? _______________ inches

Did your seat break or become unattached? Yes No (circle)

If you were driving, was the steering wheel bent or damaged? Yes No (circle)

Was your vehicle totaled? Yes No (circle)

Any other information related to the accident I may need to know? _________________________________

_____________________________________________________________________________________

**Current Symptoms:**

Since this injury occurred, are your symptoms: [ ] Improving [ ] Getting Worse [ ] Same

Are you currently suffering from any of the following? (check all that apply)

| | | | |
|---|---|---|---|
| [ ] Restlessness | [ ] Difficulty concentrating | [ ] Sleeplessness | [ ] Confusion |
| [ ] Nausea | [ ] Low heat tolerance | [ ] Face flushed | [ ] Irritable |
| [ ] Headache | [ ] Neck pain | [ ] Neck stiff | [ ] Sleeping problems |
| [ ] Back pain | [ ] Nervousness | [ ] Tension | [ ] Chest pain |
| [ ] Dizziness | [ ] Pins & Needles | [ ] Numbness | [ ] Fatigue |
| [ ] Depression | [ ] Shortness of Breath | [ ] Light sensitivity | [ ] Ears ring |
| [ ] Loss of balance | [ ] Fainting | [ ] Stomach upset | [ ] Cold sweats |
| [ ] Fever | [ ] Loss of taste | [ ] Loss of smell | [ ] Low alcohol tolerance |

What are your PRESENT complaints and symptoms?____________________________________________

_____________________________________________________________________________________

Do you have any congenital factors which relate to this problem? [ ] Yes [ ] No

If yes, please describe___________________________________________________________________

Do you have any previous illnesses which relate to this case? [ ] Yes [ ] No

If yes, please describe___________________________________________________________________

Have you ever been involved in an accident before? [ ] Yes [ ] No

If yes, please describe, including date(s) and type(s) of accidents, as well as injury(ies) received. _______

_____________________________________________________________________________________

_____________________________________________________________________________________

Did you have any physical complaints BEFORE the accident: ______________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

Have you been treated by another doctor since this accident? [ ] Yes [ ] No

If yes, please list doctor's name and address:______________________________________________

_________________________________________________________________________________

What type of treatment did you receive?__________________________________________________

_________________________________________________________________________________

Have you lost time from work as a result of this accident? [ ] Yes [ ] No

If yes, please complete:

a. Last day worked:_________________________________________________________________

b. Type of employment:_______________________________________________________________

Do you notice any activity restrictions as a result of this injury? [ ] Yes [ ] No

If yes, please describe, in detail:________________________________________________________

_________________________________________________________________________________

_________________________________________________________________________________

_________________________________________________________________________________

Other pertinent information:____________________________________________________________

_________________________________________________________________________________

Patients Signature:_________________________________________ Date:____/____/____

Print Name:______________________________________________

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**INSURANCE INFORMATION QUESTIONARE**

In order for us to bill your insurance for your complaints,
we will need the following information:

Name and billing address of YOUR auto insurance company:

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

Policy number of YOUR auto insurance policy:

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

Name and address of OTHER DRIVER'S auto insurance company:

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

Name, address and policy number of your personal health insurance company

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

Patients Signature:_______________________________________________ Date:____/____/____

Print Name:_______________________________________________