Family Chiropractic Center of Bayonne

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PERSONAL INJURY QUESTIONNAIRE

TO SAVE TIME AND ALLOW US TO BETTER SERVE YOU PLEASE COMPLETE ALL QUESTIONS

PATIENT/INSURED'S INFORMATION

Patient Last Name	First Name	M.I.	Date of Birth	Social Security Number	☐ M ☐ F
Insured's Last Name	First Name	M.I.	Date of Birth	Social Security Number	☐ M ☐ F

Insured's Address	City	State	Zip Code	Phone Number

INSURANCE COMPANY

Primary Insurance Carrier	Policy #	Claim#

Address	City	State	Zip Code	Ins. Co. Phone Number

Secondary Insurance Carrier	Policy #	Claim#

Address	City	State	Zip Code	Ins. Co. Phone Number

ATTORNEY INFORMATION

Attorney Name	Phone Number	Fax Number

Address	City	State	Zip Code

ACCIDENT INFORMATION

What type of Injury? ☐ Auto Accident ☐ Work Comp. ☐ Other	Date of Injury:	Time of Injury: ☐ AM ☐ PM	Date of First Treatment:

HISTORY OF INJURY:

In your own words, please briefly describe your how the accident happened:

____
____
____
____
____
____

PREVIOUS CONDITIONS AND TREATMENT:

In your own words, please list any previous accidents, injuries, or conditions which may have contributed to your present complaints: ____

____
____
____
____

PLEASE TURN OVER

Auto Accident Info

- ***What was your position in the vehicle?***

☐ Driver ☐ Front Passenger ☐ Rear Passenger ☐ Pedestrian (not in car)

- ***What type of vehicle were you driving or riding in?***

☐ Compact Car ☐ Mid Size Car ☐ Full Size Car ☐ Compact Truck
☐ Full Truck ☐ Mini Van ☐ Full Size Van ☐ Small SUV
☐ Lg. SUV ☐ Motorcycle ☐ Motor Home ☐ Bicycle

- ***Make and model of vehicle:___________________________***
- ***What was your vehicle doing just prior to the accident?***

☐ Stopped at a stop light ☐ Slowing down to a stop
☐ At a complete stop ☐ Increasing speed
☐ Merging into traffic ☐ Changing Lanes ☐ Other____________

- ***You were traveling at an approximate speed of __________mph.***
- ***Who hit who?***

☐ You were struck by another car ☐ Struck another car
☐ You struck a stationary object ☐ Other____________________

- ***How were the weather conditions?***

☐ Sunny ☐ Hazy ☐ Rain ☐ Sleet
☐ Snow ☐ Fog ☐ Other____________________

- ***What was your vehicle's point of impact?*** *(mark all that apply)*

☐ Front ☐ Rear ☐ Right Side ☐ Left Side
☐ Right Front ☐ Left Front ☐ Right Rear ☐ Left Rear

- ***What was the other vehicle doing just prior to the accident?***

☐ Stopped at a stop light ☐ Slowing down to a stop
☐ At a complete stop ☐ Increasing speed
☐ Merging into traffic ☐ Changing Lanes ☐ Other____________

- ***The other vehicle was traveling at an approximate speed of _____mph.***
- ***What was the other vehicle's point of impact?*** *(mark all that apply)*

☐ Front ☐ Rear ☐ Right Side ☐ Left Side
☐ Right Front ☐ Left Front ☐ Right Rear ☐ Left Rear

- ***Were you wearing seat restraints?***

☐ Full lap and shoulder restraint ☐ Lap restraint only
☐ Shoulder restraint only ☐ Was not wearing a restraint

- ***What position were your vehicle's head rests in?***

☐ Lowest position ☐ Middle position
☐ Highest position ☐ No head rest in vehicle

- ***Did your vehicle's air bags deploy?***

☐ Yes ☐ No ☐ Vehicle not equipped with air bags

- ***Were you prepared for the impact?***

☐ Came as a complete surprise ☐ Aware and braced for the collision
☐ Aware but not braced for the collision ☐ Other____________________

- ***What position was your head and neck in prior to the impact?***

☐ Straight forward ☐ Rotated to the left ☐ Rotated to the right
☐ Turned around ☐ Turned around ☐ Toward the rear view mirror

- ***What happened to your body at the moment of impact?***

☐ Body was tensed for impact ☐ Body whipped forward/backward
☐ Body torqued and twisted ☐ Body was thrown over seat
☐ Body was thrown from vehicle ☐ Body was pinned in vehicle
☐ Body was thrown from side to side ☐ Body was cut and bruised

- ***What was your mental/emotional state immediately following?***

☐ Unconscious ☐ Shaken up
☐ Disoriented ☐ Shaken up & Disoriented

- ***Did you receive medical attention at the scene of the accident?***

☐ Yes ☐ No

- ***Where did you go immediately following the accident?***

☐ Home ☐ Personal Doctor ☐ This office ☐ Resumed daily activities
☐ Hospital (if selected, please answer next question)

- ***How did you get to the hospital?***

☐ Ambulance ☐ Friend/Family member ☐ Other ____________

- ***Do you have hospital records?***

☐ Yes ☐ No

- ***Do you work:***

☐ Full time ☐ Part time ☐ Student ☐ Retired

- ***How many days were missed from work and/or school following the accident?*** ______________
- ***To your best knowledge, please list any part of your body that may have struck any part of the vehicle.*** *(For example: Right arm hit dashboard)*____

____
____
____

Workers Comp Info

If your injury involved LIFTING, complete this section:

- ***From where were you lifting an object?***

☐ Ground level ☐ A surface below ground level
☐ A surface 1 to 3 feet high ☐ A surface 3 to 5 feet high

- ***How many pounds was the object you were lifting?***

☐ 1 to 5 pounds ☐ 5 to 10 pounds ☐ 10 to 20 pounds
☐ 20 to 40 pounds ☐ 40 to 60 pounds ☐ Over 60 pounds

- ***What position were you in while lifting the object?***

☐ Back was upright and straight ☐ Bent over at the waist
☐ Twisted to the left side ☐ Twisted to the right side

- ***What type of pain did you feel immediately after the injury?***

☐ Gripping pain ☐ Sharp pain ☐ Dull pain
☐ Aches ☐ Popping feeling ☐ Paralysis

If your injury involved Falling, complete this section:

- ***From where did you fall at work?***

☐ Onto the ground while walking ☐ Onto the ground while running
☐ From 1 to 3 feet high ☐ From 3 to 5 feet high
☐ From 5 to 8 feet high ☐ From higher than 8 feet

- ***What part of your body did you land on?***

☐ Head ☐ Neck ☐ Right Shoulder ☐ Left Shoulder
☐ Right Arm ☐ Left Arm ☐ Right Hand ☐ Left Hand
☐ Back ☐ Right Buttock ☐ Left Buttock ☐ Tail Bone
☐ Right Hip ☐ Left Hip ☐ Right Leg ☐ Left Leg
☐ Right Knee ☐ Left Knee ☐ Right Foot ☐ Left Foot

- ***What other areas of your body were affected by you fall?***

☐ Head ☐ Neck ☐ Right Shoulder ☐ Left Shoulder
☐ Right Arm ☐ Left Arm ☐ Right Hand ☐ Left Hand
☐ Back ☐ Right Buttock ☐ Left Buttock ☐ Tail Bone
☐ Right Hip ☐ Left Hip ☐ Right Leg ☐ Left Leg
☐ Right Knee ☐ Left Knee ☐ Right Foot ☐ Left Foot

Other work related injuries:

☐ Raised up from bending over ☐ Twisted at the waist
☐ Wrist injury from repetitive use ☐ Wrist injury from pulling
(Please describe all injuries in your own words on page 1 of this form)

Job analysis information:

- ***What regular activities do you perform at work?***

(Please mark all that apply)
☐ Sitting ☐ Standing ☐ Walking
☐ Running ☐ Driving ☐ Lifting
☐ Bending/Stooping ☐ Squatting ☐ Crawling
☐ Climbing ☐ Crouching ☐ Kneeling
☐ Reach above Shoulders ☐ Pushing/Pulling
☐ Maintain awkward position

- ***How much do you regularly lift at work?***

☐ Little to none ☐ 1 to 10 Lbs ☐ 10 to 20 Lbs ☐ 20 to 40 Lbs
☐ 40 to 60 Lbs ☐ 60 to 80 Lbs ☐ 80 to 100 Lbs ☐ Over 100 Lbs

- ***Do you regularly bend over while lifting?*** ☐ Yes ☐ No
- ***Are your hands subject to any of the below repetitive movements?***

☐ Light grasping (left hand/Right Hand/Both) *(Please circle one)*
☐ Firm grasping (left hand/Right Hand/Both) *(Please circle one)*
☐ Typing ☐ Using a computer mouse

- ***How many hours do you regularly perform the below activities?***

Sitting: ☐ 1-2 hours ☐ 2-4 hours ☐ 4-6 hours ☐ 6-8 hours
Standing: ☐ 1-2 hours ☐ 2-4 hours ☐ 4-6 hours ☐ 6-8 hours
Walking: ☐ 1-2 hours ☐ 2-4 hours ☐ 4-6 hours ☐ 6-8 hours
Lifting: ☐ 1-2 hours ☐ 2-4 hours ☐ 4-6 hours ☐ 6-8 hours