Hurst Chiropractic, P.C.

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PERSONAL INJURY QUESTIONNAIRE

Motor Vehicle Accident

Name:_____ Today's Date:_____

Your auto insurance company:_____ Policy #_____ Claim #:_____

Your auto insurance agent:_____ Was an accident report filed with the police? [ ] Yes [ ] No

Driver of other vehicle:_____ Insurance company:_____ Claim #:_____

Have you retained an attorney? [ ] Yes [ ] No_____
Attorney's Name Firm Name Phone

Nature of Accident

Date of Accident:_____ Time of day:_____ [ ] A.M. [ ] P.M.

Location:_____

Intersecting with:_____

Police Investigation by:

[ ] Washington State Patrol [ ] Wenatchee Police [ ] East Wenatchee Police

[ ] Chelan County Sheriff [ ] Douglas County Sheriff [ ] Other_____

[ ] No investigation

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

Where were you seated in the vehicle? [ ] Driver [ ] Front seat passenger [ ] Back seat passenger

Were you aware of the approaching collision prior to impact or were you caught by surprise?

[ ] Aware of the approaching collision [ ] Caught by surprise

Did you lose consciousness (blackout) upon impact? [ ] Yes [ ] No

If yes, can you estimate for how long?_____

Was your vehicle equipped with a headrest? [ ] Yes [ ] No

Were you wearing a seat belt? [ ] Yes [ ] No

If so, what type? [ ] Lap belt only [ ] Shoulder and lap belt

Is your car equipped with an airbag? [ ] Yes [ ] No

If yes, did the air bag activate? [ ] Yes [ ] No

Were you struck from:

[ ] Behind [ ] Front [ ] Left side [ ] Right side

Was your car stopped at the time of impact? [ ] Yes [ ] No

If yes, was the driver's foot on the brake? [ ] Yes [ ] No [ ] Don't know

If the driver's foot was on the brake, was it pressing down: [ ] Slightly [ ] Moderately [ ] Strongly

If no, then estimate the speed of the vehicle you were in: _____m.p.h.

If your vehicle was moving at the time of the collision, was it slowing down, gaining speed, or traveling at a steady speed?

[ ] Slowing down [ ] Gaining speed [ ] Steady speed

Number of people in your vehicle?_____

Please describe, to the best of your knowledge, what happened during this accident:_____

_____

_____

What type of car were you in? (year, make, and model)_____

What type of car impacted with your vehicle? (year, make, and model)_____

Was the other vehicle moving at the time of the collision? [ ] Yes [ ] No

If yes, what was its approximate speed: _____m.p.h.

If the other vehicle was moving at the time of the collision, was it slowing down, gaining speed, or traveling at a steady speed?

[ ] Slowing down [ ] Gaining speed [ ] Steady speed

What bruises or cuts did you get from the accident?_____

On what part of the automobile did the following body parts hit:

Head hit_____

Chest hit_____

Right shoulder hit_____ Left shoulder hit_____

Right arm hit_____ Left arm hit_____

Right hip hit_____ Left hip hit_____

Right leg hit_____ Left leg hit_____

Right knee hit_____ Left knee hit_____

Other_____

What position was your head facing upon impact?

[ ] Forward [ ] Turned to the right [ ] Turned to the left [ ] Other_____

What position was the trunk of your body facing upon impact?

[ ] Forward [ ] Turned to the right [ ] Turned to the left [ ] Other_____

Was your vehicle pushed forward from the impact? [ ] Yes [ ] No

If yes, how much? [ ] More than one car length [ ] One-half car length

[ ] One car length [ ] Less than one-half car length

Did your car hit anything else after it was hit?_____

Describe the damage to your vehicle: [ ] None [ ] Minimal [ ] Moderate [ ] Major [ ] Totaled

_____

Which of the following car parts broke during the accident?

[ ] Windshield [ ] Front seat back [ ] Driver's side window [ ] Passenger side window [ ] Steering wheel

[ ] Other_____

Estimate given for damage to your vehicle: $_____ [ ] Estimate not yet obtained

Describe the damage to other vehicle(s): [ ] None [ ] Minimal [ ] Moderate [ ] Major [ ] Totaled

_____

Who was at-fault for the accident?

[ ] Driver of other car [ ] Driver of car I was in [ ] Myself [ ] Undetermined

Was anyone cited?_____

Emergency Care

At the site of the accident, did you receive emergency care? [ ] Yes [ ] No

Describe:_____

Where did you go after the accident? [ ] Emergency room [ ] Physician's office [ ] Home [ ] School [ ] Work

When did you receive care? [ ] Immediately [ ] Later that day [ ] Next day [ ] Days later, date:_____

By whom were you driven? [ ] Ambulance [ ] Self [ ] Family Member [ ] Friend

Treatment

Hospital Name:_____(or) Other medical facility:_____

What type of treatment did you receive?_____

X-rays:_____Medication prescribed:_____

What recommendations were you given?_____

Have you been treated by any other doctor(s) for injuries related to this accident? [ ] Yes [ ] No

If yes, please list doctors and briefly describe treatment:

1._____Dates of care:_____Type of Care:_____

2._____Dates of care:_____Type of Care:_____

3._____Dates of care:_____Type of Care:_____

4._____Dates of care:_____Type of Care:_____

Present Symptoms

What are your present complaints and symptoms?_____

_____

_____

When did your pain begin?_____

_____

Did you have the same or similar symptoms before the accident? [ ] Yes [ ] No. If yes, describe any changes or worsening:

_____

_____

Prior History

Have you ever been involved in a motor vehicle accident before? [ ] Yes [ ] No. If yes, briefly describe, including dates and injuries received:_____

_____

_____

Patient's Signature_____