PLEASE PRINT

ALTERNATIVE CARE CHIROPRACTIC CENTER

PLEASE PRINT

PERSONAL INJURY QUESTIONNAIRE:

Name____________________ Phone ( )__________

Address____________________ City__________ State_____ Zip_____

Age________ Birthdate____________ Sex_______ S/S #__________

Employer________________ Employers address________________

Ins. Co.____________________ Policy #__________

Name on policy (if other than self)____________________

Responsible Party's Name____________________

Address____________________ City__________ State_____ Zip_____

Policy holder's name____________________ Policy #__________

Attorney____________________ Phone ( )__________

Address____________________ City__________ State_____ Zip_____

NATURE OF ACCIDENT:

Date of Accident____________________ Time of Day__________

Were there any **Witness(s)**? [ ] Yes [ ] No **Names**____________________

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

# of people in your vehicle?________ Were you wearing **seatbelts?** [ ] Yes [ ] No

What direction were you headed? [ ] North [ ] South [ ] West [ ] East

On name of Street?____________________

Direction the other vehicle was headed? [ ] North [ ] South [ ] West [ ] East

On name of Street?____________________

Were you struck from: [ ] Behind [ ] Front [ ] Left side [ ] Right side

Approximate speed of your car?__________Mph Other car?__________Mph

Were you knocked **unconscious?** [ ] Yes [ ] No **If yes**, for how long?__________

Were **police** notified? [ ] Yes [ ] No Was a **police report** taken? [ ] Yes [ ] No

Did anyone receive a **ticket?** [ ] Yes [ ] No **Who?**__________

In your own words, please describe the accident:____________________

____

____

Did you have any physical complaints **before the accident?** [ ] Yes [ ] No

If so, describe in detail:____________________

____

____

Please describe how you felt:

During the accident:____________________

Immediately after the accident____________________

Later that day____________________

The next day____________________

What are your **present** complaints and symptoms?____________________