Infinity Wellness Center
Automobile/PI Accident or Work Comp Questionnaire

Name: _____ Date of Birth: _____HR# _____

Please answer all questions completely

This information is considered confidential. We need this information because we care enough to want to know and your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. In order for us to understand your condition properly, please be as neat and accurate as possible while completing this form. Thank you.

Please explain in detail how your accident happened._____

_____

_____

_____

What were the time and date of present injury? _____

Where did you feel pain immediately after the accident? _____

List the extent of your injuries as you know them:_____

_____

_____

Check symptoms you have noticed since the accident:

_____ Back pain	_____ Buzzing in ears	_____ Chest pain	_____ Cold feet
_____ Cold hands	_____ Cold sweats	_____ Constipation	_____ Depression
_____ Diarrhea	_____ Dizziness	_____ Ears ring	_____ Face flushed
_____ Fainting	_____ Fatigue	_____ Fever	_____ Head seems heavy
_____ Headache	_____ Irritability	_____ Light sensitivity	_____ Loss of balance
_____ Loss of smell	_____ Loss of taste	_____ Memory loss	_____ Neck pain
_____ Neck stiff	_____ Nervousness	_____ Numbness in fingers	_____ Numbness in toes
_____ Shortness of breath	_____ Sleeping problems	_____ Stomach upset	_____ Tension
_____ Pins and needles in legs		_____ Pins and needles in arms	

Symptoms other than above: _____

_____

Where were you taken after the accident? _____

Hospitalized? ❑Yes ❑No If yes, admitted? ❑Yes ❑No How long? _____

Name of Hospital _____

Name of Doctors _____

What treatment was given? _____

Was any other doctor consulted after your accident? ❑Yes ❑No

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If so, what was the doctor's name? _____ D.C., M.D., D.O., D.D.S.

What was the diagnosis? _____

What treatment was given? _____

How often did you see the doctor? _____

How long did you see the doctor? _____

Have you ever had any complaints in the involved area before? ❑Yes ❑No

If so, what were the complaints? _____

Before the injury were you capable of working on an equal basis with others your age? ❑Yes ❑No

Are your work activities restricted as a result of this accident? ❑Yes ❑No

Since this injury are your symptoms ❑Improving? ❑Getting worse? ❑Same?

Driver of other vehicle (if applicable)

Name _____Insurance Company _____Policy No _____

Driver of vehicle in which you were injured (if applicable)

Name _____Insurance Company _____Policy No _____

Name of your insurance adjustor _____

Have you retained an attorney? ❑Yes ❑No If so, his/her name and address _____

You were heading North/ East/ South/ West on _____ (street or highway).

Other vehicle was heading North/ East/ South/ West on _____ (street or highway).

Were police notified? ❑Yes ❑No Were you knocked unconscious? ❑Yes ❑No If so, for how long?_____

You were struck from Behind/ Front/ Left Side/ Right Side

You were Driver/ Passenger/ Front seat/ Back Seat/ Using seat belts

_____ _____

Patient's Signature (or Authorized Person) Date Completed

_____ _____

Doctor's Signature Date Reviewed