Date _____

Personal Injury Questionnaire – Low Back

Name _____ Date of Birth _____

Have you retained an Attorney? ☐ Yes ☐No If yes, please indicate name_____

NATURE OF ACCIDENT

1. Date of Accident_____ Time of Day _____
2. Were you: ☐ Driver ☐ Passenger ☐ Front Seat ☐ Back Seat
3. Number of people in your vehicle? _____ Other vehicle? _____
4. What direction were you headed? ☐ North ☐ East ☐ South ☐ West
5. What direction was the other vehicle heading? ☐ North ☐ East ☐ South ☐ West
6. Were you struck from: ☐ Behind ☐Front ☐ Left Side ☐ Right Side
7. Were airbags deployed? ☐ Yes ☐No
8. Were you wearing your seatbelt? ☐ Yes ☐No
9. Were you knocked unconscious? ☐ Yes ☐No If yes, for how long? _____
10. Were the police notified? ☐ Yes ☐No
11. In your own words, please describe the accident. _____

_____

_____

12. Where were you taken after the accident? _____
13. Please describe how you felt:

    a) DURING the accident: _____

    b) IMMEDIATELY AFTER the accident: _____

    c) LATER THAT DAY: _____

    d) THE NEXT DAY: _____

14. What are your PRESENT complaints and symptoms? _____

_____

_____

15. Have you been treated by another doctor/therapist since the accident? ☐ Yes ☐No

If yes, please list the doctor/therapist's name and address: _____

_____

16. Have you had any x-rays taken since the accident? ☐ Yes ☐No

If yes, what areas of the body were x-rayed? _____

At which facility were these x-rays taken? _____

17. Since this injury occurred, are your symptoms: ☐ Improving ☐ Getting Worse ☐ Same

18. CHECK THE SYMPTOMS YOU HAVE NOTICED **SINCE** THE ACCIDENT?

☐ Headache	☐ Irritability	☐ Numbness	☐ Face flushed	☐ Feet cold
☐ Neck pain	☐ Chest pain	☐ Shortness of breath	☐ Buzzing in ears	☐ Hands cold
☐ Neck stiff	☐ Dizziness	☐ Fatigue	☐ Loss of balance	☐ Stomach upset
☐ Sleeping problems	☐ Head seems heavy	☐ Depression	☐ Fainting	☐ Constipation
☐ Back pain	☐ Pins & needles in arms	☐ Light bothers eyes	☐ Loss of smell	☐ Cold sweats
☐ Nervousness	☐ Pins & needles in legs	☐ Loss of memory	☐ Loss of taste	☐ Fever
☐ Tension	☐ Numbness in fingers	☐ Ears ring	☐ Diarrhea	

PREVIOUS CONDITION

19. Did you have any physical complaints BEFORE the accident? ☐ Yes ☐No

If yes, please describe in detail. _____

_____

_____

20. Do you have any congenital (from birth) factors which relate to this case? ☐ Yes ☐No

If yes, please describe: _____

21. Do you have any previous illnesses which relate to this case? ☐ Yes ☐No

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

_____

_____

DISABILITY

22. Have you lost time from work as a result of the accident? ☐ Yes ☐No

If yes, please indicate:

a) Last day worked: _____

b) Type of employment: _____

c) Are you being compensated for time lost from work? ☐ Yes ☐No

If yes, please describe the type of compensation. _____

23. Did you notice any activity restrictions as a result of this injury? ☐ Yes ☐No

If yes, please describe in detail. _____

_____

_____

_____

24. Other pertinent information. _____

_____

_____

_____

_____ _____

Patient Signature Date