

**Personal Injury Questionnaire**

Name: Phone:

Address: City: State: Zip:

Age:

Birth Date:

Sex: M F SSN:

Employer’s Name: Employer’s Address: Auto Insurance Company: I Policy #: Agent’s Name: Address: City: State: Zip: Name on Policy (if other than Responsible Party’s Name: Address: City: State: Zip:

# Attorney

Name: Phone: Address: City: State: Zip: Were there any witnesses? YES NO

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: Were you wearing seat belts? YES NO
4. What direction were you headed? North South East West

On (Name of street):

1. What direction was the other vehicle headed? North South East West

On (Name of street):

1. Were you struck from: Behind Front Left side Right side
2. Approximate speed of your vehicle: mph Other car: mph
3. Were you knocked unconscious? YES NO
4. Were police notified? YES NO
5. In your own words, please describe the accident:
6. Did you have any physical complaints before the accident? YES NO

If yes, Please describe in detail:

Upper Cervical Chiropractic of Georgia

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214 S. Sunrise Dr. Raymore, MO. 64083



12. Please describe how you felt:

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1. During the accident:
2. Immediately after the accident:
3. Later that day:
4. The next day: 13: What are your PRESENT complaints and symptoms?
5. Do you have any congenital (from birth) factors which relate to this problem? YES NO
6. Do you have any previous illnesses which relate to this cause? YES NO

If yes, please describe:

1. Have you ever been involved in an accident before? YES NO

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

1. Where were you taken after the accident?
2. Have you been treated by another doctor since the accident? YES NO

If yes, please list the doctor’s name and address:

1. Since the injury occurred, are your symptoms: Improving Getting Worse Same
2. Check the symptoms you have noticed since the accident:

 Headache Head Seems Too Heavy Loss of Smell

 Back Pain Numbness in Fingers Constipation

 Chest Pain Shortness of Breath Lights Bother Eyes

 Pins and Needles in Arms Loss of Memory Buzzing in Ears

 Hands Cold Loss of Balance Loss of Taste

 Neck Pain Diarrhea Fever

 Nervousness Sleeping Problems Fatigue

 Dizziness Irritability Ears Ring

 Pins and Needles in Legs Cold Sweats Fainting

 Numbness in Toes Feet Cold Stomach Upset

 Neck Stiff Depression

 Tension Face Flushed

 Other Symptoms Other Than Above:

1. Have you lost time from work as a result of this accident? YES NO

If yes, when was the last day worked:

1. Do you notice any activity restrictions as a result of this injury? YES NO

If yes, please describe in detail:

***Patient Signature Date Date***

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