



Hoffman Chiropractic

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PERSONAL INJURY QUESTIONNAIRE

Name: _____ Date of Accident _____

Where did accident happen? Describe the accident in your own words: _____

What was your position in the car?

Driver: if Driver were your hands on the steering wheel? Left Right Both

Passenger: If Passenger, were you sitting in Front Right Rear Left Rear

Did your vehicle strike another vehicle? Yes No

Was your vehicle struck by another vehicle? Yes No

Angles of impact... First Collision: Front Back Left Right

If Second Collision: Front Back Left Right

Were you wearing a seat belt? Yes No

Did your brace for impact? Yes No... I braced with my hands I braced with my feet

Which way were you facing at the time of impact... straight ahead Left Right

Approximate speed of your car: _____ mph Other car _____ mph

Did you strike anything in vehicle at time of impact? Yes No

If yes, specify what part of your body struck what ie.... head chest chin shoulder Right/Left knee

Steering Wheel _____ Dashboard _____

Windshield _____ Roof _____

Left Side Door _____ Right Side Door _____

Left Side Window _____ Right Side Window _____

Other _____

Did back seat bend/break? Yes No

Immediately following the accident, how did you feel? dizzy/dazed disoriented unconscious

nervous nauseous upset weak other _____

Did you go to the hospital? Yes No Were you admitted to the hospital? Yes No if yes how long? _____

If you went to hospital, when? At time of accident Next day

How did you get to hospital? Ambulance Police Car Private Transportation

Name of Hospital: _____

Attended by Dr. _____

What treatment was given?

None Placed in a cervical collar X-rayed Given stitches Bandaged

Given pain med Given instructions regarding concussions

Given instructions regarding sprains and strains Physical Therapy

Instructed to call a Orthopedic Surgeon Instructed to call a private physician

Referred to this office for treatment Other _____

Have you seen any other doctor as a result of this accident? Yes No

Doctor's name
