Los Angeles Spinal Decompression ™

PERSONAL INJURY QUESTIONNAIRE

Name_______________________________ Date of Birth __________________Phone______________________

Address______________________________ City______________________ State ______Zip_________________

Employer's Name ____________________ Employer's Address______________________ Last 4 SS# __________

Your Ins. Co___________________________ Policy#____________________ Agent's Name_________________

Driver/Other Vehicle ____________________ Ins. Co _____________________ Policy# ____________________

Have you retained attorney? ( )Yes ( ) No Name ____

Were there any witnesses? ( )Yes ( )No Name(s)____

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

on (name of street) ____

5. What direction was the other vehicle headed? ( ) North ( ) East ( ) South ( ) West

on (name of street) ____

6. Were you struck from: ( ) Behind ( ) Front ( ) Left Side ( ) Right Side

7. Were you knocked unconscious? ( ) Yes ( ) No If yes, for how long? ________________________

8. Were police notified? ( ) Yes ( ) No

9. In your own words, please describe the accident: ____

____

____

10. Did you have any physical complaints BEFORE THE ACCIDENT? ( ) Yes ( ) No If yes, please describe in detail: ____

____

11. Please describe how you felt:

a. DURING the accident: ____

b. IMMEDIATELY AFTER the accident: ____

c. LATER THAT DAY: ____

d. THE NEXT DAY: ____

12. What are your PRESENT complaints and symptoms? ____

____

____

13. Do you have any previous illnesses which relate to this case? ( ) Yes ( ) No If yes, please describe:

____

14. Have you ever been involved in an accident before? ( ) Yes ( ) No If yes, please describe, including date(s) and type(s) of accidents, as well as injury(ies) received: _______________________________________

____

15. Where were you taken after the accident? ____

16. Have you been treated by another doctor since the accident? ( ) Yes ( ) No If yes, please list doctor's name and address: ____

What type of treatment did you receive?____

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

18. CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT:

___Headache	___Irritability	___Numbness in Toes	___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	___Back Pain	___Loss of Memory	___ Diarrhea	___Tension
___ Numbness in fingers	___ Ears Ring			

19. Have you lost time from work as a result of this accident? ( ) Yes ( ) No

a. Last Day Worked: ____

b. Type of Employment:____

c. Present Salary: ____

d. Are you being compensated for time lost from work? ( ) Yes ( ) No If yes, please state type of compensation you are receiving: ____

20. Do you notice any restrictions as a result of this injury? ( ) Yes ( ) No If yes, please describe in detail:

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_________________ ____

Date Patients Signature