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| **Personal Injury/Workers Comp Questionnaire**925 Benton Road Bossier City, LA 71111 |
| Name: Today’s Date: |
| Address: City/Zip: |
| Best Contact Number: Other Number:Email Address: |
| Date of Birth: Sex: M or F |
| Marital Status: |
| Employer: Occupation: |
| Date and Time of Accident: Town Where Accident Occurred: |
| **Type of Accident**1. Auto Collision
2. Pedestrian hit by car
3. Bicycle Accident
4. Slip and Fall
5. Work Accident
 |
| **Please Explain how the Accident Happened:** |
| **Auto Collision** |
| What part of your car was hit?Back End: \_\_\_Back End Passenger Side: \_\_\_ Back End Drive Side: \_\_\_ Front End: \_\_\_Front End Passenger Side: \_\_\_ Front End Driver Side: \_\_\_ Side Impact: Front, Middle, OR Rear |
| Where were you in the car?The drive of the car: \_\_\_Passenger in a car: \_\_\_If passenger were you in: Front Seat\_\_\_\_ Back Seat Right \_\_\_ Back Seat Middle \_\_\_\_ Back Seat Left \_\_\_ |
| Was your head turned upon impact? Y NWere you leaning forward at the time of impact? Y NWas your body turned at the time of impact? Y NDid you brace for the accident? Y NWere you wearing your seat belt? Y NDid the airbag deploy? Y N |
| **List the extent of injuries, as you know them:**  |
| **When did the symptoms first appear?** |
| **Where did you go immediately after the accident:**Home: \_\_\_\_ Emergency Room: \_\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_If you went to an emergency room, please list name and address of hospital: |
| Were X-Rays Taken? Y N What area of body?Was medication prescribed? Y N What medication?What was the doctor’s diagnosis and recommendation? |
| **Have you been seen by any other doctors or chiropractors for this condition?** Y NIf yes, please answer the following:Name and address of doctor (s): Dates seen:Were X-Rays Taken? Y NWhat Treatment was provided?  |
| **Have you ever had any injury (ies) or complaint (s) similar to those you are experiencing now? Y N****Describe:** |
| **Did you miss any work because of this injury?** Y N If yes, please list specifically, from: to:  |
| **Please describe in detail your physical work activities: (i.e., sitting for 2-3 hours in front of a computer screen, lifting heavy objects across the room 10x per day, etc.)** |

This information is considered confidential.  We need this information to help determine how

Chiropractic may help you, as well as filling out the necessary insurance forms.  Please take the time to

complete this form as accurately as possible.  Thank you.