Gaskin Family Chiropractic, P.C.
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PERSONAL INJURY QUESTIONNAIRE

Full Legal Name Today's Date:

How long before you felt symptoms from the crash? ☐ Immediately ☐ ______ hour(s) ☐ ______ day(s)
☐ week(s) ☐ Some symptoms felt immediately, others came on later
Any pains or symptoms PRIOR to the crash? ☐ Yes ☐ No
PRIOR TO the crash, did you have any trouble with: ☐ Headaches ☐ Neck pain ☐ Mid back pain
☐ Low back pain ☐ Shoulder pain ☐ Wrist pain ☐ Loss of taste or smell
Besides you, how many others were in the vehicle? # ________
Have you ever been in any other car crashes ? ☐ No ☐ Yes
If yes, did you get hurt ? ☐ No ☐ Yes Dates of other car crashes: ________________________

Date of accident: Did the police come to the crash scene? ☐ Yes, ☐ No Accident report made? ☐ Yes, ☐ No Photographs taken of the vehicles? ☐ Yes, ☐ No

Were you "**on the job**" at the time of crash? ☐ Yes ☐ No

Vehicle Type:	☐ Sports car	☐ Coupe	☐ Sedan	☐ SUV	☐ Motorcycle	**Vehicle Size**	☐ compact	☐ light	☐ mini
	☐ Station Wagon	☐ Pick-up Truck	☐ Truck	☐ Van	☐ Other		☐ Full size	☐ Midsize	

Position in vehicle:	☐ Driver	☐ Front middle passenger	☐ Front Right passenger	☐ Back Left Passenger	☐ Back Middle Passenger	☐ Back Right Passenger

Vehicle driven by: Vehicle make, model & yr.

Was any one else in the vehicle with you? ☐ Yes ☐ No Who?:

Were you wearing a seatbelt? ☐ Yes ☐ No If so, what type? ☐ Lap only ☐ Shoulder & lap

Did air bags activate? ☐ Yes ☐ No ☐ Car not equipped with air bag

My **estimated speed** at time of impact was? mph I was? ☐ Stopped ☐ Slowing ☐ Accelerating

At time of crash, brakes applied? ☐ Yes ☐ No

If your foot was on the brake, was it pressing down: ☐ Slightly ☐ Moderately ☐ Strongly

Accident happened at a/an? ☐ Stop sign ☐ Intersection ☐ Traffic light ☐ Highway ☐ Other

Road condition: ☐ Dry ☐ Damp ☐ Wet ☐ Snow ☐ Ice ☐ Hailing ☐ Other

Time of day: ☐ daylight ☐ Dawn ☐ Dusk ☐ Dark

Visibility: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Visibility compromised by: ☐ Brightness ☐ Rain ☐ Fog ☐ Snow ☐ Traffic

My seat **headrest**? ☐ Was adjustable ☐ Not adjustable It was: ☐ Up ☐ Down ☐ Don't recall

If it was adjustable: was its original position changed by the crash? ☐ Yes ☐ No

Head position?	Looking forward?	Turned: Right? or Left?	Looking up?	Looking down?
Body position?	Good	Leaning forward	Other	
Hand position?	One on the wheel	Two on the wheel	Don't remember	

What direction was the crash impact in relation to where you were seated? (Circle one only)?

Front Rear Left side Right side Left front Left rear Right front Right rear

Describe in DETAIL "in your own words" exactly how the crash happened:

DURING THE CRASH:

Were you taken by surprise, u**naware of the impending crash**?	☐ Yes	☐ No	
Did any part of your **body strike any part of the vehicle**:	☐ Yes	☐ No	If yes, describe:
Did you **lose consciousness**?	☐ Yes	☐ No	If yes, how long?
Did vehicle strike any objects after the crash?	☐ Yes	☐ No	
Were you wearing a hat or glasses? ☐ Yes ☐ No	Were they still on after the crash?	☐ Yes	☐ No

AFTER THE CRASH:

Immediately after the crash, were you able to walk without help? ☐ Yes ☐ No

Where did you go after the accident? ☐ Home ☐ Hospital ☐ Work ☐ School

Were you taken my ambulance anywhere? ☐ Yes ☐ No If yes, where?

What was done there? ☐ Exam ☐ X-rayed ☐ Given medicine ☐ Collar/brace

If x-rayed, what body parts were imaged?

If given medication: name and dosage:

Any follow up doctor instructions given? ☐ Yes ☐ No If yes, what were they?

Have you seen any other doctor before coming here? ☐ Yes ☐ No If yes, complete this section.

Dr.	Specialty	Treatment
Dr.	Specialty	Treatment

Have you missed work due to this injury? ☐ Yes ☐ No From To

PAST HISTORY OF INJURY:

Have you ever had the same or similar symptoms before this crash? ☐ Yes ☐ No Explain?

Do you have any disabling conditions or physical impairments not due to this injury? ☐ Yes ☐ No If yes, explain:

Who owns the vehicle in which you were hit? ______________________________
What is the estimated repair damage to your vehicle? $______________ ☐ Unknown, ☐ Estimate not done
How many people were in your vehicle at the time of the crash? ____________

By signing this form, I attest that the information is complete and accurate to the best of my knowledge.

Signature ________________________________ **Date** ________________