Michels Spinal Rehab Associates
Out of injury, back to life

Personal Injury Questionnaire

Name:_____ **DOB**:_____ **Chart #:**_____

Height:_____ **Weight**:_____ **Handness**: □ **R** □ **L**

Accident Date:_____ **Time**:_____**am/pm**

Injury Detail

Were you the: □ **Driver** □ **Passenger** □ **Pedestrian**

If **Driver**, were your hands on the steering wheel? □ **R** □ **L** □ **Both**

If **Passenger**, were you in the: □ **Front seat** □ **Right rear seat** □ **Left rear seat**

Seat belt worn at time of impact: □ **Yes** □ **No** Was the seat belt: □ **3 point** □ **Lap only**

Does your vehicle have **head rests**? □ **Yes** □ **No** **Location:** □ **Head** □ **Neck** □ **Below neck**

Were you aware that the accident was going to happen? □ **Yes** □ **No**

Did you **brace for impact?** □ **Yes** □ **No**…If **yes**: □ braced w/**hands** □ braced w/**feet**

At the time of impact were you: □ **looking straight** □ **looking to right** □ **looking to left**

□ **looking down** □ **looking up**

Did **your vehicle** strike the other vehicle:□ **Yes** □ **No OR** were **you struck by them**? □**Yes** □ **No**

Did **airbags deploy** on impact? □ **Yes** □ **No**

Was the **impact** from: □ **right center** □ **right rear** □ **left rear** □ **right side** □ **front center**

□ **front right** □ **right front** □ **left front** □ **left side**

Was your vehicle in: □ **park** □ **neutral** □ **in gear** □ **moving** □ **stopped**

Did the vehicle go into a **spin or roll** as a result of the impact? □ **Yes** □ **No**

If **yes**, explain:_____

Was **your vehicle** shoved: □ **forward** □ **backward** □ **sideways**

Were **you** shoved: □ **forward** □ **whipped backward** □ **sideways R/L**

Did any other part of **your body hit** the interior of the vehicle? □ **Yes** □ **No**

If **yes**, please specify: □ **seat belt restraints** □ **steering wheel** □ **dashboard** □ **windshield**

□ **side door** □ **side window** □ **other**_____

Which **part of your body:** _____

Loss of consciousness: □ **Yes** □ **No…**If **yes,** how long?_____

After the accident, did you feel: □ **Disoriented** □ **Dizzy/Dazed** □ **Nervous** □ **Nauseous**

□ **Upset** □ **Weak** □ **Other**_____

How **long** did this last?_____

Vehicle Information

Your vehicle: Make/Model/Year:_____ **Your** speed:_____MPH

Damage to **your** vehicle: □ **None** □ **Mild** □ **Moderate** □ **Severe** □ **Totaled**

Other vehicle: Make/Model/Year:_____ **Their** speed:_____MPH

Damage to **their** vehicle: □ None □ Mild □ Moderate □ Severe □ Totaled

Treatment

Did you go to the hospital/Urgent Care: □ **Yes** □ **No**

Name of hospital/Urgent Care:_____

Attending Doctor:_____

When did you go to hospital: □ **Following the accident** □ **Next day**

How did you get to hospital: □ **Ambulance** □ **Police car** □ **Private transportation**

Did you **stay** at the hospital: □ **Yes** □ **No**

If **yes**, how long: □ **Examined/Released** □ **Short Observation** □ **1 Day** □ **Multiple Days**

What **treatment** did you receive: □ **none** □ **cervical collar** □ **x-rays** □ **stitches** □ **bandages**

□ **medication:** _____

□ **instructions on concussions** □ **instructions on strains/sprains**

□ **physical therapy** □ **instructed to call a specialist**

□ **instructed to receive follow up care by a physician** □ **referred to this office**

Have you **seen additional doctors** as a result of this accident: □ **Yes** □ **No**

Doctors' names/address and treatment (ie: Dr. Smith, Valley Orthopedic; arm brace/medication):

1._____

_____

2._____

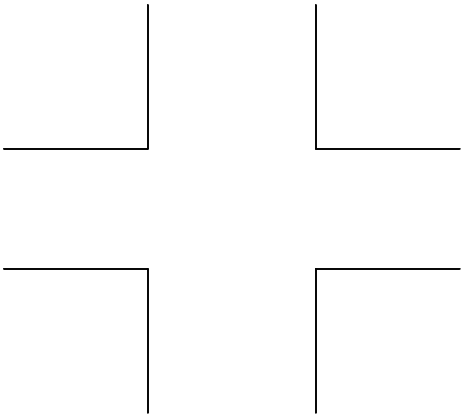
_____

3._____

_____

Accident Description

Position of cars



Describe accident in your own words:_____

_____

_____

_____

_____

_____

Accident Location: (Street, Intersection, highway)_____

_____

Street conditions: □ **Dry** □ **Wet** □ **Icy** □ **Fog**

□ **Other**_____

Car 1: Your car

Car 2: Their car

(Add more if needed)

Did **police** arrive on scene: □ **Yes** □ **No**

Were **citations** written: □ **Yes** □ **No**

If **yes**, to who: □ **You** □ **Other driver** □ **Both**

Have **you** filled out an **accident report:** □ **Yes** □ **No**

Past Medical History:

Have you had **previous injuries/accidents** (Workers Comp/Auto Accident) □ **Yes** □ **No** If **yes**, explain:_____

Is there any **residual pain from previous injury:** □ **Yes** □ **No** How much **better** did you feel **prior to current accident** (ie: 80%, 100%):_____

Current Medications:_____

_____

Other significant **past** medical history:_____

Current Complaints:

Onset of symptoms: □ **Immediately** □ **Later in day** □ **Later in week**

Since the accident, have your complaints: □ **Improved** □ **Worsened** □ **Unchanged**

Neck/Upper Back

Describe neck/upper back pain:_____

Experienced **headaches** since accident: □ **Yes** □ **No**

If **yes**: Intensity: □ **Mild** □ **Moderate** □ **Severe** Duration: □ **Constant** □ **Intermittent**

Experienced **arm/hand numbness/weakness:** □ **Yes** □ **No** □ **Right** □ **Left**

If **yes**: Intensity: □ **Mild** □ **Moderate** □ **Severe** Duration: □ **Constant** □ **Intermittent**

Specific area (ie: pinkie, thumb):_____

Mid/Low Back_____

Describe mid/low back pain:_____

_____

Experienced **leg numbness/weakness**: □ **Yes** □ **No** □ **Right** □ **Left**

If **yes**: Intensity: □ **Mild** □ **Moderate** □ **Severe** Duration: □ **Constant** □ **Intermittent**

Specific are (ie: little toe, ankle):_____

Other_____

Experienced difficulty in **chewing** or **"popping"** within the **jaw** since accident: □ **Yes** □ **No**

If **yes**: □ **right side** □ **left side** □ **both sides**

Experienced **ringing in ears/loss of balance** since accidents: □ **Yes** □ **No**

If **yes**: Intensity: □ **Mild** □ **Moderate** □ **Severe** Duration: □ **Constant** □ **Intermittent**

Experienced **visual abnormalities or disturbances**: □ **Yes** □ **No**

If **yes**: Intensity: □ **Mild** □ **Moderate** □ **Severe** Duration: □ **Constant** □ **Intermittent**

Since the accident have **you** felt: □ **Dizziness** □ **Nervousness** □ **Fatigue** □ **Anxiety**

□ **Depression** □ **Excessive Irritability** □ **Trouble Sleeping** □ **Fear of Driving**

□ **Loss of Concentration** □ **Jaw Clenching** □ **Teeth Grinding** □ **Other**_____

Have you retained an **attorney:** □ **Yes** □ **No**

If **yes**, **name/phone number**: _____

The information that has been provided on this form has been given to the best of my knowledge, ability, and recollection.

Patient Signature:_____ Date:_____