

# Personal Injury Questionnaire

*Bromberg Chiropractic Office*

201 Broadway Cambridge MA 02139

Dear Patient: 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.

Name \_\_\_\_\_ Sex \_\_\_\_\_ Today's Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Address \_\_\_\_\_ Home Tel (\_\_\_\_) \_\_\_\_\_ Work Tel (\_\_\_\_) \_\_\_\_\_

City, Zip \_\_\_\_\_ Soc. Sec \_\_\_\_\_ - \_\_\_\_ - \_\_\_\_ Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Marital Status \_\_\_\_\_ Email Address \_\_\_\_\_

=====

1) **Date and time** of accident \_\_\_\_/\_\_\_\_/\_\_\_\_, \_\_\_\_\_ Town where accident occurred \_\_\_\_\_

2) **Type of accident:**

a. Auto Collision \_\_\_\_\_ b. Pedestrian hit by car \_\_\_\_\_ c. Bicycle accident \_\_\_\_\_, d. Slip and Fall \_\_\_\_\_  
e. Work Accident \_\_\_\_\_.

3) Please explain how the accident happened: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

4) **Auto Collision:**

What part of your car was hit?

Back end \_\_\_\_\_, Back end passenger side \_\_\_\_\_, Back end driver side \_\_\_\_\_, Front  
end \_\_\_\_\_, Front end passenger side \_\_\_\_\_, Front end driver side \_\_\_\_\_, Side impact: Side  
front \_\_\_\_\_, Side middle \_\_\_\_\_, Side rear \_\_\_\_\_.

Where were you in the car?

The driver of the car \_\_\_\_\_, Passenger in a car \_\_\_\_\_, If Passenger were you in: front  
seat \_\_\_\_\_, Back Seat Right \_\_\_\_\_, Back Seat Middle \_\_\_\_\_, Back Seat Left \_\_\_\_\_.

a. Was your head turned upon impact? \_\_\_\_\_ b. Were you leaning forward at the time of impact? \_\_\_\_\_ c. Was your body turned at the time of impact? \_\_\_\_\_ d. Did you brace for the accident? \_\_\_\_\_ e. Were you wearing your seat belt? \_\_\_\_\_ f. Did the airbag deploy? \_\_\_\_\_

g) Did you bump your head during the accident? \_\_\_\_\_ If yes, what part of your head was struck? \_\_\_\_\_, Where on the car did you hit your head? \_\_\_\_\_

5) List the extent of injuries, as you know them: \_\_\_\_\_

6) When did the **symptoms first appear**? \_\_\_\_\_

7) Where did you go immediately after the accident? Home \_\_\_\_\_ Emergency room \_\_\_\_\_ other \_\_\_\_\_

a) If you went to an emergency room, please list name and address of hospital \_\_\_\_\_

b) Were x-rays taken? Yes \_\_\_ No \_\_\_ What area of body? \_\_\_\_\_

c) Was medication prescribed? Yes \_\_\_ No \_\_\_ Name: \_\_\_\_\_

d) What was the Doctor's diagnosis and recommendation? \_\_\_\_\_

8) Have you been seen by any other doctors or chiropractors for this condition? Yes \_\_\_ No \_\_\_

If so, please fill out below

a) Name and address of doctor(s): \_\_\_\_\_

b) Dates seen: \_\_\_\_\_

c) Were x-rays taken? \_\_\_\_\_ What treatment was provided? \_\_\_\_\_

a) Name and address of doctor(s): \_\_\_\_\_

b) Dates seen: \_\_\_\_\_

c) Were x-rays taken? \_\_\_\_\_ What treatment was provided? \_\_\_\_\_

9) Have you ever had any injuries or complaints similar to those you are now experiencing? Y\_\_ N\_\_

Describe: \_\_\_\_\_

10) Did you **miss any time at work** because of this injury? Yes \_\_\_ No \_\_\_

If yes, please list specifically when: From \_\_\_\_\_ to \_\_\_\_\_

11) 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 10 times per day, etc.)

\_\_\_\_\_

**Insurance Information:**

1) Are you the **owner of the vehicle** you are traveling in? Yes \_\_\_ No \_\_\_  
If not, please **list name and address of owner:**

\_\_\_\_\_  
Your **relationship** to owner \_\_\_\_\_

2) Insurance **company of vehicle you were traveling in:**

\_\_\_\_\_  
Policy # \_\_\_\_\_ Claim # \_\_\_\_\_

3) Insurance company of other vehicle in accident:

\_\_\_\_\_  
Owner's name and address \_\_\_\_\_

4) Are you **covered** by any type of health insurance? Yes \_\_\_ No \_\_\_  
If so, please list insurance company name and policy #: (please provide front desk with card)

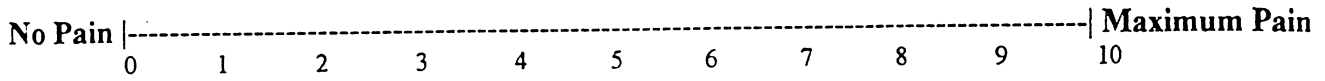
\_\_\_\_\_  
5) Have you obtained an attorney? Yes \_\_\_ No \_\_\_  
If so, please list name and phone number:

\_\_\_\_\_  
**I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic office will prepare any necessary reports and form to assist me in making collection from the insurance companies. However, I clearly understand and agree that all services rendered to me are charged to me, and that ultimately I am personally responsible for payment.**

Patient signature \_\_\_\_\_ Date \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date \_\_\_\_\_

1) Indicate with a **mark** on this line, the level of pain you are now experiencing:



2) Listed below are **5 types** of pain. **Select the type** (or types) of pain that you are experiencing.

3) Mark the body figures (**draw below**) to indicate where on your body the pain is being felt.

Be sure to **use the corresponding symbols** for each type of pain.

4) Please **draw your face** on the figure below.

XXXXXX  
 Numbness XXXXXXXXXXXX  
 XXXXXX

SSSSS  
 Stabbing SSSSSSSSS  
 SSSSS

/////////  
 Ache ///////////////  
 ///////////

Pins and Needles  
 OOOOO  
 OOOOOOOOOO  
 OOOOO

Burning  
 +++++  
 ++++++++  
 +++++

