# 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? ________________________

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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 you 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 r**elationship** 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)
_______________________________________________________________________

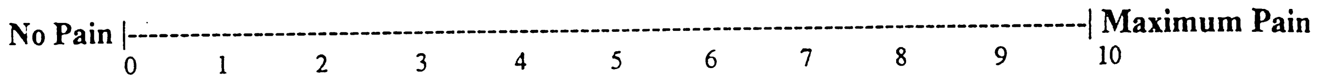
5) Have you obtained an attorney? Yes ___ No ___
If so, please list name and phone number:
_______________________________________________________________________

**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 you 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.

Numbness
XXXXX
XXXXXXXXXX
XXXXX

Stabbing
SSSSS
SSSSSSSSS
SSSSS

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

Pins and Needles
OOOOO
OOOOOOOOOO
OOOOO

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