

K A K L E A S
CHIROPRACTIC INC

A CHIROPRACTIC AND
PHYSICAL THERAPY CENTER

PERSONAL INJURY QUESTIONNAIRE

FULL NAME _____ EMAIL; _____
ADDRESS _____ TEL # _____
CITY _____ ZIP _____
AGE _____ BIRTHDATE _____ SEX _____ SS# _____ / _____ / _____
SPOUSE'S NAME _____ BIRTHDATE _____
Employer _____ Employer Address _____
Tel # _____ Occupation _____

YOUR AUTO INSURANCE INFORMATION:

Name of Insured _____ Policy # _____
Insurance Company _____ Tel # _____
Address _____ City _____ Zip _____
Amount of "Medical Payment" _____ Adjuster _____
PLEASE GIVE US A COPY OF THE COVERAGE PAGE OF YOUR AUTO POLICY.

AUTO INSURANCE OF THE OTHER PARTY INVOLVED:

Name of Insured _____ Policy # _____
Insurance Company _____ Tel # _____
Address _____ City _____ Zip _____
Adjuster _____

YOUR HEALTH INSURANCE INFORMATION:

Name of Insured _____ Relationship to you _____
Insurance Company _____
Group or Plan # _____ Tel # _____
Insured SS# _____ Dependants _____
PLEASE BE SURE TO GIVE US A COPY OF YOUR INSURANCE I.D. CARD.

ATTORNEY INFORMATION (IF APPLICABLE):

Attorney Name _____ Tel # _____
Address _____ City _____ Zip _____

ACCIDENT INFORMATION In your own words please describe the accident
in detail:

Date of Accident ____/____/____ Time of Day _____ am/pm

Were you: () Driver () Passenger () Front Seat () Back Seat

How many passengers were in your car with you?: _____

Was there a police Report?: () YES () NO

CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT:

- () Headache () Irritability () numbness in Toes () Face Flushed () Feet Cold
- () Neck Pain () Chest Pain () Shortness Breath () buzzing in ears () Hands Cold
- () Neck Stiff () Dizziness () Fatigue () Loss of Balance () Stomach Upset
- () Sleeping Problems () Head seams heavy () Depression () Fainting () Constipation
- () Back Pain () Pins & Needles in arm () Light bothers eyes () Loss of smell () Cold Sweats
- () Nervousness () Pins & Needles in legs () Loss of memory () Loss of taste () Fever
- () Tension () numbness in fingers () Ears ringing () Diarrhea () other _____

Symptoms other than above: _____

Did you receive any other medical/ Chiropratic care directly after the accident: () YES () NO

If yes, please describe:

Please describe your PRESENT symptoms and complaints:

Since the car accident, have your symptoms:

- () Improved () Stayed the same () Gotten Worse

Do you notice restrictions in any other area of your life as a result of this accident?:

Have you lost any time from work as a result of this accident?: () YES () NO

Did you have any physical complaints before the accident?: () YES () NO

Please Describe: _____

Other pertinent information:

Signed: _____

Date: _____

Legal guardian (if applicable) _____

Date: _____