Alpine Chiropractic Center
833 W Commercial Dr.
Wasilla, AK 99654
(907)376-2475

PERSONAL INJURY QUESTIONNAIRE

Name_____Date of Accident: _____

<u>YOUR</u> INSURANCE INFORMATION:
(Regardless of fault – this must be complete or provide a copy of your insurance card)

Insurance Company Name:_____
Address: _____
Phone Number: _____ Fax number: _____
Adjuster's Name: _____ Claim #: _____
Is there Med Pay Coverage? (if unsure, ask your adjuster): ( ) Yes ( ) No Amount: _____

Do you have health insurance? ( ) Yes ( ) No
Insurance Company Name: _____ ID#_____

Do not settle your liability claim with the other party or insurance company without confirmation that your account is being paid in full and the check is sent directly to the clinic. If you receive settlement and your account has a balance, it is your obligation to pay in full at time of settlement.

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NATURE OF ACCIDENT:

1. Were you: ( )The Driver ( )The Passenger ( )In Front Seat ( )In Back Seat
2. Number of people in your vehicle? _____ Were you wearing seat belts? _____
3. Were you struck from: ( ) Behind ( ) Front ( ) Left side ( ) Right side
4. Approximate speed of your car: _____mph Other car: _____mph
5. Was this vehicle equipped with airbags? ( ) Yes ( ) No
6. If yes, did they inflate? ( ) Yes ( ) No
7. Were you knocked unconscious? ( ) Yes ( ) No If yes, for how long? _____
8. Did emergency personnel respond? ( ) Yes ( ) No
9. Where you transported for medical care? ( ) Yes ( ) NO
10. In your own words, please describe accident:

_____
_____
_____

11. Did you have any physical complaints BEFORE THE ACCIDENT? ( ) Yes ( ) No
    If yes, please describe in detail:

    _____

    _____

    _____

12. Please describe how you felt:
    a. DURING the accident :_____
    b. IMMEDIATELY AFTER the accident:_____
    c. LATER THAT DAY:_____
    d. THE NEXT DAY:_____
13. What symptoms do you have as a result of this accident?

    _____

    _____

    _____

    _____

14. Have you been treated by another doctor since the accident? ( ) Yes ( ) No
    If yes, please list the Doctor's name:_____

    _____

15. Since this injury occurred, are your symptoms: ( ) Improving ( ) Getting worse ( ) Same
16. CHECK SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT:

__ Headache	__Irritability	__Numbness in toes	__Face Flushed	__Feet Cold
__Neck pain	__Chest pain	__Shortness of breath	__Buzzing in ears	__Hands cold
__ Neck stiff	__Dizziness	__Fatigue	__ Loss of balance	__Stomach upset
__Sleeping problem	__Head seems heavy	__Depression	__ Fainting	__ Constipation
__Back pain	__Pins & Needles- (arms)	__Lights bother eyes	__Loss of smell	__Cold sweats
__Nervousness	__ Pins & Needles- (legs)	__Loss of Memory	__Loss of taste	__Fever
__Tension	__Numbness in fingers	__ Ears ring	__Diarrhea	__Other

    Symptoms other than above:_____

17. Do you notice any activity restrictions as a result of this injury? ( ) Yes ( ) No
18. If yes, please describe in detail:_____

    _____

    _____

Date:_____ Signature:_____