Chino Valley **Family Chiropractic**

Occupational Injury Questionnaire (Please Print) Rev 3/06

Name_____ Date_____

Please explain in detail how accident happened. _____

_____

_____

_____

Time/Date present injury occurred_____ AM/PM_____ 20_____
What address were you at when injured? _____
What injuries did you suffer? _____

_____

Since the injury are your symptoms ☐ improving? ☐ getting worse? ☐ about the same?
Are your work activities restricted as a result of this accident? ☐ Yes ☐ No
Did you notify your employer of this injury? ☐ Yes ☐ No With whom did you speak? _____
When was the last day you worked?_____
Did you return to work? ☐ Yes ☐ No If so, date returned_____
Did you consult any other doctor? ☐ Yes ☐ No If so, when_____
If so, doctor's name_____ ☐ D.C., ☐ M.D., ☐ D.O., ☐ D.D.S
Doctor's diagnosis and treatment received? _____
Have you ever injured this area before? ☐ Yes ☐ No If so, when?_____
If injured before, did you lose time from work? ☐ Yes ☐ No
If you lost time from work with injuries prior to this injury, give names and doctors consulted._____

_____

Do any other diseases or accidents affect your employment? ☐ Yes ☐ No If so, explain_____

_____

In your work, do you have to favor any part of your body? ☐ Yes ☐ No If so, explain_____

_____

Do you have a history of absenteeism caused from accidents on the job? ☐ Yes ☐ No
Have you ever had a workers compensation claim before? ☐ Yes ☐ No
Before the injury were you capable of working on an equal basis with others your age? ☐ Yes ☐ No

Name of Insurance Company:_____
Have you retained an attorney? ☐ Yes ☐ No Litigation? ☐ Yes ☐ No ☐ Maybe
If yes, please give name: _____
Address_____ City/State_____ Zip_____ Phone (____)_____

Patients Signature_____ Date_____

Chino Valley **Family Chiropractic**

Motor Vehicle Accident Questionnaire (Please Print) Rev 3/06

Name_____ Date_____

Accident information **(Fill out completely, if does not apply put N/A)**

Please describe the collision in your own words? _____

_____

_____

_____

Where did the collision occur? City/Town: _____State: _____

Date of collision: _____Time: _____ AM/PM

Were you the: ☐ **driver** ☐ **passenger** ☐ **pedestrian**

What type of vehicle were you in? _____ What type was the other vehicle? _____

Was there a second impact? _____

Was the impact from: ☐ **the front** ☐ **the rear** ☐ **the left side** ☐ **the right side**

What was the approximate speed at the time of impact? **Your vehicle** _____ **mph; Other Vehicle** _____**mph**

How much damage was there to the outside of your vehicle? ☐ **none** ☐ **some** ☐ **a lot**

Were you wearing a seat belt? ☐ **yes** ☐ **no**

Does your vehicle have an airbag? ☐ **yes** ☐ **no** Did it deploy? ☐ **yes** ☐ **no**

Immediately after the accident, where did you experience pain? Be specific: _____

_____

Immediately after the accident were you: ☐ **conscious** ☐ **dazed** ☐ **unconscious** How long? _____

Were you surprised by the impact? ☐ **yes** ☐ **no**

Did you go to the hospital? ☐ **yes** ☐ **no** If yes, how did you get there? _____

If you went to the hospital or saw another doctor, please answer the following?

Hospital Name_____ **Doctor Name**_____

Diagnosis_____ **Treatment received**_____

Tests_____

Have you retained an attorney? ☐ Yes ☐ No Litigation? ☐ Yes ☐ No ☐ Maybe

If yes, please give name: _____

Address_____ City/State_____ Zip_____ Phone (____)_____

Auto Insurance company_____

Address/phone_____

_____

Claim number:_____

Liable Party's Insurance company_____

Address/Phone_____

_____

Claim number:_____

Patients Signature_____ Date_____