

**WELLNESS CONCEPTS OF FLORIDA, L.L.C.**  
**PERSONAL INJURY QUESTIONNAIRE**

Name \_\_\_\_\_ Date \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Other Phone (\_\_\_\_) \_\_\_\_\_ Marital Status: M S W D  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Age \_\_\_\_\_ Birth Date \_\_\_\_\_ Sex: M F Social Security # \_\_\_\_\_  
Occupation \_\_\_\_\_ E-mail \_\_\_\_\_  
Employer \_\_\_\_\_ Work Phone \_\_\_\_\_  
Work Address \_\_\_\_\_  
Spouse's Name \_\_\_\_\_ Spouse's Employer \_\_\_\_\_  
Name of Emergency Contact \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_  
How do you prefer to be verbally addressed? Mr./ Mrs./ Ms./ Dr./ First Name/ Other \_\_\_\_\_  
Present Complaint \_\_\_\_\_

Where you previously treated for this condition?  Yes  No If yes, by:  Chiropractor  M.D.  Therapist  
 Other PLEASE SPECIFY DATES AND TREATMENT RESULTS. \_\_\_\_\_

Did you have any physical complaints BEFORE THE ACCIDENT?  Yes  No If Yes, describe in detail:

Please describe the character of you current pain. Check all that apply:  Sharp  Stabbing  Burning  
 Shooting  Achey  Soreness  Weakness  Throbbing  Tingling  Numbness  Dull  Gripping  
 Constricting  Other \_\_\_\_\_

Symptoms are present?  Constant/ 100% of the time  Frequent/ 75%  Intermittent/ 50%  Occasional/ 25%

Describe the intensity of the pain:  Minimal  Mild  Moderate  Severe/Excruciating

Since the problem began, is the pain:  Increasing  Decreasing  Not Changing

Pain is aggravated by:  Walking  Sitting  Riding in Car  Standing  Lifting  Bending  Stretching  
 Twisting  Other \_\_\_\_\_

Pain is decreased by  Medication  Rest  Exercise  Therapy  Chiropractic Adjustments  
 Other \_\_\_\_\_

Are you complaints worse:  Upon rising  Mid-day  Evening  At Night

Any fever or chills?  Yes  No

Any change in bladder or bowel (bathroom) function?  Yes  No

FAMILY DOCTOR/PRIMARY CARE PHYSICIAN: \_\_\_\_\_

Is there anyone you would like us to keep informed regarding your treatment at the office? E.g. family physician, referring doctor, etc.  Yes  No Name and Address \_\_\_\_\_

What is your exercise routine? \_\_\_\_\_

Do you smoke?  Yes  No How much? \_\_\_\_\_

What non-prescription medication are you taking? Tylenol \_\_\_\_\_ Ibuprofen \_\_\_\_\_ Aspirin \_\_\_\_\_  
Other \_\_\_\_\_

What prescription Medications or Drugs are you taking?

\_\_\_ Anti-Inflammatory      \_\_\_ Pain Killer      \_\_\_ Muscle Relaxers  
\_\_\_ Blood Pressure      \_\_\_ Insulin      \_\_\_ Tranquilizers  
\_\_\_ Birth Control      \_\_\_ Nerve Pills      \_\_\_ Diet Pills  
\_\_\_ Other \_\_\_\_\_

Have you ever fractured or broken a bone?  Yes  No  
Please list ANY Surgical History, Past Illnesses, and/or serious diseases and/or injury \_\_\_\_\_  
\_\_\_\_\_

**NATURE OF THE ACCIDENT**

Date of the Accident \_\_\_\_\_ Time of Day \_\_\_\_\_

Where you:  Drive  Passenger  Front Seat  Back Seat # of passengers \_\_\_\_\_

In your own words, please describe the accident: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Where you working, on work time, or was driving associated with business at the time of the accident? Y N

Were you wearing seat belts? Yes No      Were you wearing hat or glasses: Yes No  
If yes, were they still on after the crash? Yes No

What street were you traveling on ? \_\_\_\_\_ What street was the other vehicle traveling on? \_\_\_\_\_  
\_\_\_\_\_ Where you struck from:  Behind  Front  L. Side  R.Side

Approx. speed of your car? \_\_\_\_\_ MPH Other car \_\_\_\_\_ MPH

Where you knocked unconscious? Yes No If yes, how long? \_\_\_\_\_

Where Police notified? Yes No

Where you taken to a hospital emergency room? Yes No Where \_\_\_\_\_

Please describe how you felt:  
IMMEDIATELY AFTER the accident: \_\_\_\_\_  
LATER THAT DAY: \_\_\_\_\_  
THE NEXT DAY: \_\_\_\_\_

Where you aware of approaching collision prior to impact, or did it take you by surprise? \_\_\_\_\_

How far is the headrest of seat back form the back of your head? (approximately) \_\_\_\_\_

Was the seat back adjustment altered by the accident? Yes No Was the seat broken? Yes No

Did an air bag deploy? Yes No If yes, were you struck? Yes No

What is the make, model, and year of your vehicle? \_\_\_\_\_

What is the make, model, and year of other vehicles involved? \_\_\_\_\_

Did the windshield break during the accident? Yes No

At the time of impact, which direction were you looking? \_\_\_\_\_

What were the road conditions at the time of the accident? \_\_\_ Wet \_\_\_ Dry \_\_\_ Icy \_\_\_ Other \_\_\_\_\_

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Patient Name \_\_\_\_\_

Other pertinent information: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you missed any days of work or school due to the injury? Yes No If yes, how many? \_\_\_\_\_

Your Car Insurance Co. \_\_\_\_\_ Phone # \_\_\_\_\_  
Agent \_\_\_\_\_

Name on Policy (if other than self) \_\_\_\_\_  
Policy # \_\_\_\_\_ Claim # \_\_\_\_\_

Your Major Medical Ins. Co. \_\_\_\_\_ ID# \_\_\_\_\_

Where you at fault? Yes No If someone else was at fault, their name \_\_\_\_\_  
Their Insurance Co. Name \_\_\_\_\_ Phone # \_\_\_\_\_

Have you contracted with an attorney? Yes No Name of Attorney \_\_\_\_\_  
Phone # ( ) \_\_\_\_\_ Address \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_

Where there any witnesses? Yes No Their Name (s) \_\_\_\_\_

Mark an X on the picture where you have pain or other symptoms. (E.g. Pain, numbness, tingling, soreness, etc)

