PERSONAL AUTO INJURY QUESTIONNAIRE (Page 1 of 2)

Aamodt CHIROPRACTIC
1805 44th St. S.E.
Grand Rapids, MI

Today's Date: _____

NAME: _____ Date of Auto Accident _____

Where did accident happen? Describe the accident in your own words:

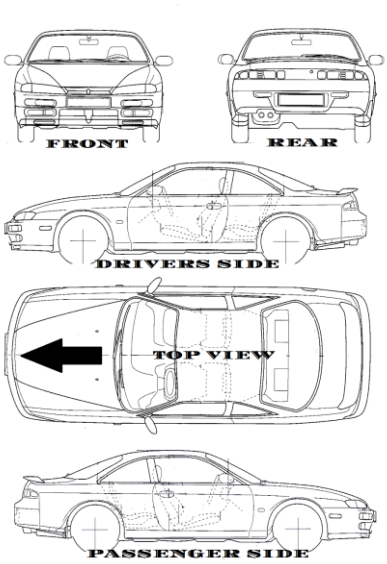

Figure 1 Sketch Your Car's Damage

What was your position in the car?

□ Driver:...facing □ Forward □ Head Turned... Braced for impact? □ Yes □ No

□ Passenger:...sitting in □ Front □ Right Rear □ Left Rear... Braced for impact? □ Yes □ No

Did your vehicle strike another vehicle □ Yes □ No

Was your vehicle struck by another vehicle □ Yes □ No

Areas of impact… First Collision: □ Front □ Back □ Left □ Right

... Secondary Collision?: □ Front □ Back □ Left □ Right

Were you wearing a seat/shoulder belt? □ Yes □ No

Did you brace for impact? □ Yes □ No … □ I braced with my hands □ I braced with my feet

Which way were you facing at the time of impact… □ straight ahead □ Left □ Right

Was a police report made of this accident? □ Yes □ No □ Unsure

Did your body strike anything in vehicle at time of impact? □ Yes □ No

...If yes, specify what part of your body struck what:

(example… "Steering Wheel ~ *hit my head*", "Left Side Door ~ *hit my Lt shoulder*")

Damage Estimate? $_____

□ Steering Wheel _____ □ Dashboard _____

□ Windshield _____ □ Roof_____

□ Left Side Door _____ □ Right Side Door_____

□ Left Side Window _____ □ Right Window _____

□ Other _____

Did your seat back bend / break ? □ Yes □ No

Immediately following the accident, how did you feel? □ dizzy/dazed □ disoriented □ immediate pain/complaint

□ nervous □ nauseous □ upset □ weak □ Other _____

Did you lose consciousness? □ Yes □ No □ Unsure

Did you go to a hospital □ Yes □ No Were you admitted to the hospital? □ Yes □ No (if yes how long?) _____

If you went to hospital, when? □ At time of accident □ Next day □ ____ days after the accident

How did you get to hospital? □ Ambulance □ Police Car □ Private Transportation of my choice

Name & location of Hospital:_____

What was their diagnosis? _____

… what treatment was given? *(check all that apply)*

☐none ☐placed in a cervical collar ☐x-rayed ☐ CT ☐MRI ☐ given stitches ☐Bandaged

☐given pain medication ☐given instructions regarding concussions ☐ given lumbar brace to wear

☐given instructions regarding sprains and strains ☐ ER exam & released ☐ Physical Therapy

☐instructed to call a Orthopedic Surgeon ☐instructed to call my primary care physician

☐referred to this office for treatment ☐ Other Care _____

_____

Have you seen any other doctors or medical facilities as a result of this accident? □ Yes □ No □ Pending

Describe Other Care: _____

PERSONAL AUTO INJURY QUESTIONNAIRE (cont'd - page 2)

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Grand Rapids, MI

1 Upper Body Concerns: (*check this box if applies)*

☐ **Neck or Torso Complaints**

	Circle Rating Below
*Mark the areas of **Pain** with "P"*	"P" 0-1-2-3-4-5-6-7-8-9-10
*Mark areas of **Stiffness** with "S"*	"S" 0-1-2-3-4-5-6-7-8-9-10
*Mark areas of **Tingling** with "T"*	"T" 0-1-2-3-4-5-6-7-8-9-10
Frequency of these complaints	Rare--Frequent--Constant

Ringing in Ears	☐Yes	☐No	☐Left	☐Right
Blurry Vision	☐Yes	☐No	☐Left	☐Right
Arm/Hand Pain	☐Yes	☐No	☐Left	☐Right
Jaw Pain	☐Yes	☐No	☐Left	☐Right
Headache	☐Yes	☐No		

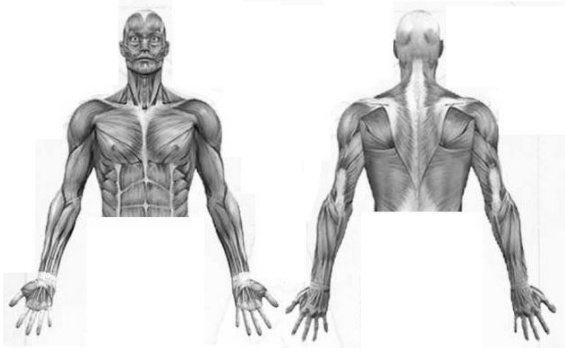

Figure 2 Sketch Your Upper Body/Neck Complaint(s)

2 Lower Body Concerns: (*check this box if applies)*

☐ **Low Back or Leg Complaints**

	Circle Severity Below
Mark the areas of pain with "P"	"P" 0-1-2-3-4-5-6-7-8-9-10
Mark areas of Stiffness with "S"	"S" 0-1-2-3-4-5-6-7-8-9-10
Mark areas of Tingling with "T"	"T" 0-1-2-3-4-5-6-7-8-9-10
Frequency of these complaints	Rare--Frequent--Constant

Leg Pain	☐ Yes	☐ No	☐ Left	☐Right
Hip Pain	☐ Yes	☐ No	☐ Left	☐Right
Knee Pain	☐ Yes	☐ No	☐ Left	☐Right
Foot Pain	☐ Yes	☐ No	☐ Left	☐Right

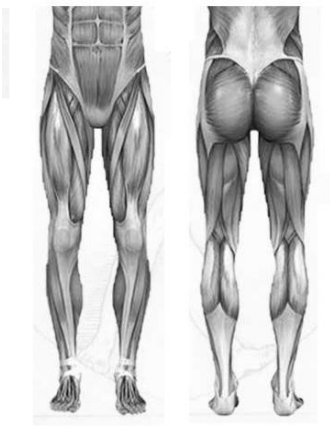

Figure 3 Sketch Your LB/Leg Complaint(s)

3 Other Body Concerns: (*check this box if applies)*

☐ **Other Symptoms or Complaints**

Cognitive issues, functional loss, work loss or head trauma

☐ Dizziness ☐ nervousness ☐ fatigue ☐ anxiety ☐ depression ☐ excessive irritability ☐ poor memory
☐ fear of being in a car ☐ trouble concentrating ☐ jaw clenching ☐ disturbed emotional feelings
☐ nightmares ☐ difficulty sleeping at night ☐ worse in morning ☐ worse at night ☐ unpredictable symptoms

Additional Symptoms/ Complaints:

Have You lost any time from work due to your injuries? ☐Yes ☐No

If yes please give approx dates: _____ Has a doctor officially excused these dates? ☐Yes ☐ No

Your Employer: _____ Job Description: _____

Have you had any prior auto accidents or possible related personal injuries? ☐Yes ☐ No

Description of previous Auto Accident: _____

Description of previous Injuries: _____

Were your current areas of complaint symptomatic (already sore) prior to this new accident? ☐Yes ☐ No ☐ Unsure

Describe any limitations (activities of daily living) you are experiencing now, which you feel could be due to this auto accident:

(This form is to be completed by the patient.) *Please Sign and date* _____ *Date:* _____