

Account # _____

RENO CHIROPRACTIC CENTER

210 EAST GROVER ST SHELBY, NC
Across from Cleveland Regional Medical Center
704-480-1700

PERSONAL INJURY QUESTIONNAIRE

(PLEASE BE VERY SPECIFIC WITH YOUR ANSWERS...THANK YOU!)

NAME: _____ DATE: _____

1. What was the date of the accident? _____
2. What time did the accident occur? _____
3. How many vehicles were involved in the accident? _____
4. What was the estimated damage to the vehicle you were in? _____
5. What street or intersection were you on when the accident occurred? _____
6. What direction were you traveling in? _____
7. What city did the accident occur in? _____
8. What state did the accident occur in? _____
9. What type of impact was the auto accident? _____
10. Did your vehicle hit anything after the accident? if yes, please describe _____
11. Where were you sitting in the vehicle during the accident? _____
12. Did you know the accident was coming? _____
13. What type of vehicle were you in? _____
14. What type of vehicle impacted yours? _____
15. At the time of the impact, how fast was your vehicle moving? _____
16. At the time of impact, how fast was the other vehicle moving? _____
17. During and after the crash what happened to your vehicle? (circle all that apply)
 - kept going straight
 - kept going straight hitting a car in front
 - was hit by another vehicle
 - spun around
 - spun around and hit a stationary object
 - hit a stationary object
18. Did you lose consciousness during the accident? No Yes
19. How was your head positioned during the accident? _____
20. How was your torso positioned during the accident? _____
21. How were your hands positioned during the accident? _____
22. Did your head hit anything during the accident? No Yes, please describe _____
23. Did your face hit anything during the accident? No Yes, please describe _____
24. Did your shoulders hit anything during the accident? No Yes, please describe _____
25. Did your neck hit anything during the accident? No Yes, please describe _____
26. Did your chest hit anything during the accident? No Yes, please describe _____
27. Did your hips hit anything during the accident? No Yes, please describe _____
28. Did your knees hit anything during the accident? No Yes, please describe _____
29. Did your feet hit anything during the accident? No Yes, please describe _____
30. What kind of headrest was in your vehicle?
 - movable fixed headrest
 - nonmovable fixed headrest
 - no headrest

31. Where was the headrest positioned on your head? _____
32. Did you have your seatbelt on during the accident? No Yes
33. Did you slide out of your seatbelt during the accident? _____
34. What was damaged in your vehicle? (Circle all that apply)
- windshield
 - steering wheel
 - dashboard
 - seat frame
 - side window
 - rear window
 - rear bumper
 - front bumper
 - trunk
 - front left door
 - front right door
 - back left door
 - mirror
 - knee bolster
 - back right door
 - completely totalled
35. Choose the items that dented inward
- floorboards
 - side door
 - dashboard
36. Choose the doors that would not open as a result of the accident
- front left
 - front right
 - rear left
 - rear right
37. Did you go to the hospital? If no, why and do not answer 38-43 _____
38. How did get to the hospital? _____
39. What was the name of the hospital? _____
40. Were you hospitalized over night? _____
41. Circle what you were prescribed at the hospital
- pain medication
 - muscle relaxors
 - neck brace
42. Did you recieve any stitches for any cuts at the hospital? _____
43. Were x rays taken at the hosiptal? If yes, which area was taken? _____

SIGNATURE OF PATIENT: _____ **DATE:** _____