Dr. Kenzie Maloy, DC, DABCI, DACCP, DACBN
505 E. Main St. Suite B
Hermiston, OR 97838
Phone: 541-371-3700
Fax:541-515-7022

PERSONAL INJURY QUESTIONNAIRE

Name ______________________________ Date of Birth ________________________ Phone ____________________

Address ________________________________ City ___________________________ State ________ Zip _________

Employer's Name _______________________________ Employer's Address _________________________________

Your Ins. Co. ____________________________ Policy# ____________________ Agents Name __________________

Driver/Other Vehicle _____________________________ Ins. Co. ______________________ Policy# _____________

Have you retained an attorney?

( ) Yes ( ) No Name ____

Were there any witnesses?

( ) yes ( ) No Name (s) ____

NATURE OF ACCIDENT:

1. Date of Accident ____ Time of Day________________________
2. Indicate by drawing where you were sitting and the direction of impact:
3. Number of people in your vehicle? ____________________________ Other vehicle? ______________________
4. What direction were you headed?
   ( ) North ( ) East ( ) South ( ) West
   On (name of street) ____
5. What direction was other vehicle headed?
   ( ) North ( ) East ( ) South ( ) West
   On (Name of street) ____
6. Did your head hit:
   ( ) Head Rest ( ) Windshield ( ) Steering Wheel ( ) Roof ( ) Flying Object ( ) Other
7. At the moment of impact were you:
   ( ) Wearing Seat Belt ( ) Braking ( ) Wearing Lap Belt ( ) Bracing for Impact ( ) Aware Accident Would Happen
8. At the moment of impact was your head:
   ( ) Left ( ) Right ( ) Straight

9. At the moment of impact what was your sitting position?
   ( ) Knees Left ( ) Knees Right ( ) Knees Straight ( ) Torso turned

10. Other Injuries:
    ( ) Knee ( ) Leg ( ) Ankle ( ) Foot ( ) Hip ( ) Other

11. Were you knocked unconscious?
    ( ) Yes ( ) No If yes, for how long? ____

12. Were police notified?
    ( ) Yes ( ) No

13. In your own words, please describe accident: ____

____

____

____

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

15. Please describe how you felt:

    a. DURING the accident: ____

    b. LATER THAT DAY: ____

    c. THE NEXT DAY: ____

16. What are your PRESENT complaints and symptoms? ____
    ____
    ____

17. Do you have any congenital (from birth) factors which relate to this problem?
    ( ) Yes ( ) No If yes, please describe: ____

18. Do you have any previous illnesses which relate to this case?
    ( ) Yes ( ) No If yes, please describe: ____

19. Have you ever been involved in an accident before?
    ( ) Yes ( ) No If yes, please describe, including date(s) and type(s) of accident(s) as well as injury(ies) received:
    ____
    ____
    ____

20. Where were you taken after the accident? ____

21. Have you been treated by another doctor since the accident?
    ( ) Yes ( ) No If yes, please list doctors name and address: ______________________________
    What type of treatment did you receive? ______________________________
    ____
    ____

22. Since this injury occurred, are your symptoms:
    ( ) Improving ( ) Getting worse ( ) Same

23. CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT:

□Headache	□Head seems too heavy	□Fatigue	□Fainting
□Neck Pain	□Pins and needles in arms	□Depression	□Loss of smell
□Neck Stiff	□Pins and needles in legs	□Lights bother eyes	□Loss of taste
□Sleeping problems	□Numbness in fingers	□Loss of memory	□Diarrhea
□Back pain	□Numbness in toes	□Ears Ring	□Feet cold
□Nervousness	□Shortness of breath	□Face Flushed	□Hands cold
□Tension		□Buzzing in ears	□Stomach upset
□Irritability		□Loss of balance	□Constipation
□Chest pains			□Cold sweats
□Dizziness			□Fever

Symptoms other than above? ______________________________

24. Have you lost time from work as a result of this accident?
    ( ) Yes ( ) No If yes, please complete this question.
    a. Last day worked: ______________________________
    b. Type of Employment: ______________________________
    c. Present Salary: ______________________________
    d. Are you being compensated for time lost from work?
       ( ) Yes ( ) No If yes, please state type of compensation you are receiving. ____________

25. Do you notice any activity restrictions as a result of this injury:
    ( ) Yes ( ) No If yes, please describe, in detail: ______________________________
    ____
    ____

26. Other pertinent information: ______________________________
    ____
    ____
    ____

Date: ____________________ Patient's Signature: ______________________________