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### PERSONAL INJURY QUESTIONNAIRE

1. Date of accident: \_\_\_\_/\_\_\_\_/\_\_\_\_ Time of day: \_\_\_\_\_ am / pm
2. Were you the: \_\_\_ Driver \_\_\_ Passenger in the: \_\_\_ Front seat \_\_\_ Back seat
3. Number of people in your vehicle: \_\_\_\_\_ Were you wearing seat belts? \_\_\_ Yes \_\_\_ No
4. Were you struck from: \_\_\_ Behind \_\_\_ Front \_\_\_ Left Side \_\_\_ Right Side
5. Approximate speed of your car: \_\_\_\_\_ mph Other car: \_\_\_\_\_ mph
6. Were you knocked unconscious? \_\_\_ Yes \_\_\_ No If yes, for how long? \_\_\_\_\_
7. Were police notified? \_\_\_ Yes \_\_\_ No
8. In your own words, please describe the accident: \_\_\_\_\_  
\_\_\_\_\_
9. Please describe how you felt:
  - a. DURING the accident: \_\_\_\_\_
  - b. IMMEDIATELY AFTER the accident: \_\_\_\_\_
  - c. LATER THAT DAY: \_\_\_\_\_
  - d. TODAY: \_\_\_\_\_
10. What are your PRESENT complaints and symptoms? \_\_\_\_\_  
\_\_\_\_\_
11. Since the injury, are your symptoms: \_\_\_ Improving \_\_\_ Getting worse \_\_\_ the Same
12. Did you have any physical complaints BEFORE the accident? \_\_\_ Yes \_\_\_ No  
If yes, please describe in detail: \_\_\_\_\_  
\_\_\_\_\_
13. Have you ever been involved in an accident before? \_\_\_ Yes \_\_\_ No  
If yes, please describe the accident, including date(s), type(s) of accidents, and injuries sustained: \_\_\_\_\_  
\_\_\_\_\_
14. Have you been treated by another doctor since the accident mentioned in #1? \_\_\_ Yes \_\_\_ No  
If yes, please list the doctor's name and address: \_\_\_\_\_  
\_\_\_\_\_
- What types of treatment did you receive? \_\_\_\_\_
15. Have you lost time from work as a result of this accident? \_\_\_ Yes \_\_\_ No
16. Do you notice any activity restrictions as a result of this injury? \_\_\_ Yes \_\_\_ No  
If yes, please describe in detail: \_\_\_\_\_  
\_\_\_\_\_
17. Other pertinent information: \_\_\_\_\_  
\_\_\_\_\_

Signature of Patient or Representative: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Printed Name of Patient or Representative: \_\_\_\_\_