Personal Injury Questionnaire

Services provided by Trevor Winzoski Chiropractic Corp.
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CLAIM # ________________________

Last name   First Name   Date of Birth

Today's Date:________________________ (M/D/YY)   Date of Collision:________________________ (M/D/YY)

List primary complaints/injuries that developed as a result of the motor vehicle accident:

1. ______________________________   5. ______________________________
2. ______________________________   6. ______________________________
3. ______________________________   7. ______________________________
4. ______________________________   8. ______________________________

Describe the accident in your own words:

____

____

____

I was: ☐ The driver ☐ A Front Passenger ☐ A Rear Passenger ☐ A Pedestrian ☐ A Cyclist

Area of Impact ☐ Front ☐ Drivers side ☐ Passengers side ☐ Back

Did the Airbag go off? ☐ Yes ☐ No

Did you strike anything in the vehicle?____
Did you lose consciousness? ☐ Yes ☐ No   Did you go to the hospital? ☐ Yes ☐ No

Have you lost time from work because of these injuries? ☐ Yes ☐ No
If yes, how much time off?__________________ Current work status? ☐ Full Duties ☐ Modified duties ☐ Not at work

Have you experienced injuries similar to those noted above within the past 2 years of this accident?
(describe)____
____
____

Within the past 2 years of this accident:

Yes	No	
☐	☐	1. Have you had a previous MPI claim or WCB elected motor vehicle accident claim?
☐	☐	2. Has your function or mobility been significantly impacted by arthritis?
☐	☐	3. Have you undergone any treatment for cancer or other significant illness?
☐	☐	4. Have you received supportive care (such as palliative care, etc.)?
☐	☐	5. Have you been under active treatment for psychiatric or psychological conditions?
☐	☐	6. Have you had any significant injuries that may affect your recovery from this accident?

What injuries and how were you injured?____

Have you seen any other healthcare providers for these injuries? ☐ Yes ☐ No
If yes, who? And when?____
____

I herby authorize the release of information and reports pertaining to these injuries to MPI for the duration of this claim: ______________________________________

Signature of Patient or Guardian   Date (M/D/YY)