Koehler Chiropractic Offices
232 NORTH MAIN
BOURBONNAIS, ILLINOIS 60914
815-939-4900

Date_____

PERSONAL INJURY QUESTIONNAIRE

Name_____Date of Injury_____Phone_____
Address_____City_____State_____Zip_____
Employer's Name_____Employer's Address_____
Your Ins. Co._____Policy #_____Agent's 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. Were you: ( ) Driver ( ) Front Seat Passenger ( ) Left Rear Seat ( ) Right Rear Seat
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. Were you struck from: ( ) Behind ( ) Front ( ) Left Side ( ) Right Side
7. Were you knocked unconscious? ( ) Yes ( ) No If yes, for how long?_____
8. Were police notified? ( ) Yes ( ) No
9. In your own words, please describe accident:_____
   _____
   _____
   _____
10. Were you earing a seat belt? ( ) Yes ( ) No If so, what type ( ) Lap ( ) Shoulder
11. Did your seat have a head restraint (headrest)? ( ) Yes ( ) No
    If so, what was the position of the head restraint? ( ) Low ( ) Midposition ( ) High
12. Did your vehicle strike the other vehicle? ( ) Yes ( ) No
13. Was your vehicle struck by the other vehicle? ( ) Yes ( ) No
14. What was the approximate speed at the time of impact? Your vehicle_____mph Other vehicle_____mph
15. What were the road conditions? ( ) Dry ( ) Wet ( ) Icy
16. At the time of impact were you: ( ) Looking straight ahead ( ) Looking to the right
    ( ) Looking to the left ( ) Looking down ( ) Looking up
17. Were both hands on the steering wheel? ( ) Yes ( ) No If no, which hand? ( ) Left ( ) Right
18. Was your foot on the brake? ( ) Yes ( ) No If so, which foot? ( ) Left ( ) Right
19. Were you braced at the time of impact? ( ) Yes ( ) No
20. Did you strike anything at the time of impact? ( ) Yes ( ) No
    If so, please specify ( ) Seatbelt restraints ( ) Steering wheel ( ) Dashboard ( ) Windshield
    ( ) Side door ( ) Side window ( ) Other_____
    Please state part of body: ( ) Chest ( ) Head ( ) Chin ( ) Face ( ) Rt/Lt knee ( ) Rt/Lt shoulder
    ( ) Rt/Lt hand ( ) Other_____

21. Please describe how you felt:
    a. DURING the accident:_____
    b. IMMEDIATELY AFTER the accident: ( ) Conscious ( ) Dazed ( ) Unconscious
    c. LATER THAT DAY:_____
    d. THE NEXT DAY:_____
22. What are your PRESENT complaints and symptoms?_____
    _____
    _____
23. Do you have any congenital (from birth) factors which relate to this problem? ( ) Yes ( ) No
24. Do you have any previous illnesses which relate to this case? ( ) Yes ( ) No
    If yes, please describe:_____
25. Where were you taken after the accident?_____
26A. Have you been treated by another doctor since the accident? ( ) Yes ( ) No
    If yes, please list doctor's name and address:_____
    What type of treatment did you receive?_____
26B. Did you go to the hospital? ( ) Yes ( ) No
    If so, when? ( ) At time of accident ( ) Next day ( ) Other
26C. How did you get to the hospital? ( ) Ambulance ( ) Private transportation
    If by ambulance, did the ambulance attendants place you in a: ( ) Neck brace ( ) Back brace
    ( ) Other_____
26D. If you went to the hospital, please answer the following:
    Name of Hospital_____
    Name of Doctor_____
    Diagnosis_____
    Treatment received_____
27. Since this injury occurred, are your symptoms: ( ) Improving ( ) Getting Worse ( ) Same
28. 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. Are you being compensated for time lost from work? ( ) Yes ( ) No
        If yes, please state type of compensation you are receiving:_____
29. Do you notice any activity restrictions as a result of this injury? ( ) Yes ( ) No
    If yes, please describe, in detail:_____
    _____
30. Requested medical records form:
    1. _____
    2. _____
    3. _____
31. Have you ever been involved in an accident before? ( ) Yes ( ) No
    If yes, please describe, including date(s) and type(s) of accidents, as well as injury(ies) received:_____
    _____

Date_____Signature_____