THE ARNE CLINIC
Chiropractic and Natural Medicine

PERSONAL INJURY QUESTIONAIRE

PATIENT INFORMATION

First Name: _____ MI: ____ Last Name: _____

Address: _____ City: _____ State: ____ Zip: _____

Mobile Phone: _____ Email: _____

Have you retained an attorney? ☐ YES ☐ NO Name: _____ Phone: _____

Auto Insurance Company: _____ Claim #: _____

Contact Name: _____ Phone: _____

NATURE OF ACCIDENT

Date of accident: _____ Time of Day: _____ City and State: _____

Were you: ☐ Driver ☐ Passenger ☐ Other Were you in the: ☐ Front Seat ☐ Back Seat ☐ Other

Number of people in your vehicle: _____ Number of people in other vehicle: _____

Direction YOU were headed: ☐ North ☐ South ☐ East ☐ West On what street? _____

Direction OTHER vehicle headed: ☐ North ☐ South ☐ East ☐ West On what street? _____

Were you struck from: ☐ Behind ☐ Front ☐ Left Side ☐ Right Side Were Police notified? ☐ YES ☐ NO

Did you lose consciousness? ☐ YES ☐ NO If YES, for how long? _____

Were you hospitalized? ☐ YES ☐ NO If YES, for how long? _____

Describe the accident in your own words: _____

_____

_____

Have you ever been involved in an accident before? ☐ YES ☐ NO If YES, list the dates, type of accident(s), and related injuries: _____

_____

Did you have any physical complaints PRIOR TO THE ACCIDENT? ☐ YES ☐ NO If YES, describe in detail: _____

_____

Describe how you felt: IMMEDIATELY AFTER THE ACCIDENT: _____

Describe how you felt: LATER, ON THE DAY OF THE ACCIDENT: _____

Describe how you felt: THE DAY AFTER THE ACCIDENT: _____

THE ARNE CLINIC
Chiropractic and Natural Medicine

PAGE 2 - PERSONAL INJURY QUESTIONAIRE

Describe your PRESENT complaints and symptoms: _____

_____

_____

_____

Since this injury occurred, are your symptoms: □ Improving □ Staying the same □ Getting worse

Check the symptoms you have experienced since the accident:

□ Headache	□ Nervousness	□ Numbness-fingers	□ Buzzing in ears
□ Neck pain	□ Irritability	□ Numbness-toes	□ Ringing in ears
□ Neck stiffness	□ Depression	□ Pins & needles-arm	□ Loss of hearing
□ Back pain	□ Fatigue	□ Pins & needles-legs	□ Loss of smell
□ Chest pain	□ Loss of memory	□ Hands cold	□ Loss of taste
□ Shortness of breath	□ Dizziness	□ Feet cold	□ Stomach upset
□ Lights bother eyes	□ Fainting	□ Fever	□ Constipation
□ Head seems heavy	□ Loss of balance	□ Cold sweats	□ Diarrhea
□ Blurred vision	□ Disorientation	□ Face flushed	□ Sleep problems

Have you lost time from work because of this accident? □ YES □ NO

If YES, are you: □ Totally disabled □ Partially disabled

Describe restrictions: _____

_____

_____

Have you been treated by another doctor since this accident? □ YES □ NO

Name of Doctor/Clinic: _____ Phone: _____

If YES, type of treatment(s) that you received: _____

_____

Other pertinent information: _____

_____

_____

_____

Patient Signature: _____ Date: ____/____/_____

12991 Ridgedale Drive, Minnetonka, MN 55305 | (952) 541-0200 | bewell@arneclinic.com