**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: _____

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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