The Hetrick Center

Personal Injury Questionnaire

Patient Name: _____ Date of Birth: _____

- Date of Accident? _____ Time of Accident?_____
- Location of Accident: _____
- In your own words, how did the accident occur? _____
  _____
  _____
  _____
  _____
- Were you the driver or a passenger in the automobile? _____ If you were a passenger, what position were you sitting in the automobile? _____
- How many people were in your vehicle? _____ Other vehicle (s)? _____
- What is the make, model, and year of your automobile? _____
- What is the make, model, and year of the other vehicle(s)? _____
- What were the road surface conditions (dry, wet, snow, ice, etc)? _____
- How fast were you traveling? _____; The other vehicle? _____
- What type of damage was done to your vehicle? _____
- What type of damage was done to the other involved vehicle(s)?_____
- Were you aware the accident was going to occur, did you see it coming? __Yes ___No
- Did you hear any tires screeching? ___Yes ___No
- If you struck the vehicle in front of you, did you hit it straight on, off to the left, or off to the right? _____
- If you were hit from behind, was the impact more from the center, or more to the left or right? _____
- Was your foot on the brake at the time of impact? ___Yes ___No. If yes, ddi your car move forward after the impact? ___Yes ___No
- Where did your vehicle end up after the accident? (i.e. did not move, moved slightly, ended in a ditch, etc) _____
- Where did the other involved automobile(s) end up after the accident? _____
  _____
- Did anything in the vehicle strike you? ___Yes ___No. If yes, what and where?
  _____

- What was the position of your head (looking/turned to the left/right, looking straight ahead, looking in the rearview mirror, etc)?_____
- What was the position of your hands on the steering wheel at the time of the accident? (ie 1- & 2 o'clock) _____
- What was the position of your legs/feet? _____
- Were you sitting straight up? ___Yes ___No. If you weren't, were you leaning to the side (right or left), slumped in your chair, etc? _____
- What was the distance from the back of your head to the headrest? ____ inches. What was the height of the headrest? _____
- Were you wearing the appropriate seat restraints? ___Yes ___No. Were you wearing shoulder restraints, lap restraints, or both? _____
- If you were wearing eyeglasses/sunglasses, did they remain on your face? ___Yes ___No. Did you have to readjust your glasses after impact? ___Yes ___No
- Were you wearing any accessories on your head? ___Yes ___No. Were the accessories still on your head after the accident? ___Yes ___No. What accessories are you referring to? _____
- Do you have any pictures of your vehicle following the accident? ___Yes ___No
- Do you remember your head being whipped back and forth? ___Yes ____No If yes, which direction was your head whipped? _____
- Did your head strike anything in the vehicle? ___Yes ___No. If yes, what? _____
- Were your airbags released? ___Yes ___No
- Did you have to be extricated out of the vehicle? ___Yes ___No. Were you able to get out of the car on your own? ___Yes ___No
- Were you taken from the accident via ambulance? ___Yes ___No. Were you examined and/or treated by an emergency medical crew at the site of the accident? ___Yes ___No If you went to the hospital, whether via ambulance or on your own, where were you taken? _____
- Have you been examined/treated by any other health care providers? ___Yes ___No. If yes, please tell us who/when/where/how often/etc _____ _____
- Have you been prescribed any medications for conditions sustained in this motor vehicle accident? Yes or No. If yes, what have you been prescribed? _____ _____
- Have you had any special studies (xrays, CAT scans, MRI's, etc) performed for this accident? Yes or No If yes, what? _____ _____
- Did you have any visible injuries immediately after the accident? Yes or No. If yes, what? _____ Do you have any pictures of the visible injuries? __Yes ___No. If this is more than 3 days after the accident, have you noticed bruising on your body? __Yes or __No If yes, where? _____

- Have you ever been involved in a motor vehicle accident in the past? If yes, what date? _____ Nature of the accident_____
- Do you remember everything from the time of impact until after the impact? Yes or No Did you lose consciousness as a result of the accident? __Yes __No.
- Have you noticed any visual disturbances as a result of the accident? __Yes __No Have you had any ringing of the ears? __Yes __No Anything else? _____
- Were you nauseated as a result of the accident? ___Yes ____No Did you vomit within the first 24 hours following the accident? __Yes ___No Were you dizzy? ___Yes ___No
- Are you experiencing any jaw pain? __Yes __No Right/Left/Bilateral
- What symptoms do you have as a result of the accident (ie neck/back pain, arm/leg pain, headaches, extremity complaints, etc)?_____
  _____
- Describe your pain ie burning, sharp, dull, etc _____
  _____
- Do you have any radiating arm or leg pain? ___Yes ___No
- Are your symptoms __Getting worse __Staying the same ___Getting better
- Does anything make your pain better or worse? _____
  _____
- Is your pain worse with coughing, sneezing, or going to the bathroom? ___Yes ___No
- Have there been any changes in bowel/bladder function since the accident? __Yes __No
- Are you having any problems with memory or concentration as a result of your motor vehicle accident? __Yes __No. Describe: _____
- Did you hear anything pop, snap, or ear after the accident? __Yes ___No
- What is your current pain level (0-10 scale) with 0 being no pain and 10 being the worst pain that you could ever imagein? ___/10 When you feel the best, what is your pain level? ___/10. When you feel the worst, what is your pain level? ___/10.
- Are you current symptoms with you 25%, 50%, 75%, or 100% of the time…Mark down which symptoms are with you via those percentages.
  100%_____
  75% _____
  50%_____
  25%_____
- Did you have any complaints prior to the accident you were involved in? ___Yes ___No If yes, list these areas and write what the pain leven (1-10) was prior to the motor vehicle accident at its best, worst, and average. _____
  _____
  _____
  _____

- Have you worked since the accident? ___Yes ___No; If yes, __FT __PT __Intermittent
- If yes to above, are you on limited duty? ___Yes ___No Describe: _____
- Are you having difficulty performing your daily activities? ___Yes __No If yes, what are you having difficulty performing? _____
  _____

- Are you having difficulty sleeping since the accident? __Yes __No Describe: _____
- Is there anything else we have not asked you that you feel is pertinent to this case?
  _____
  _____
  _____
  _____

Patient's Printed Name: _____

I have answered the above truthfully and to the best of my knowledge,

Patient Signature _____ Date_____

Provider Signature _____ Date _____

□ Ed Bartakovits DC □ Christy Carroll MS, PT □ Mary Colman DC □ Scott Colman DC □ Timothy Duke DC □ Allyson Eisenhour PT, DPT □ Amy Heckman PT, MPT □ Paul Hetrick DC □ Edward Hevner DC □ Charlene Hobbie DC □Leonard Sargent DC