PERSONAL INJURY QUESTIONNAIRE

BENTLEY CHIROPRACTIC, INC.

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Tel (419) 893-0231
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Patient Name: _____ Birthdate: _____

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

Phone #: Home ( ) _____ Cell ( ) _____

Social Security #: _____ Sex: ☐ Male ☐ Female

Your Car Ins. Company: _____ Agent Name: _____

Attorney: _____ Phone: ( ) _____

Were police notified? ☐ Yes ☐ No Witness Names (if any) _____

Date of Accident: _____ Time: _____

Position in vehicle: ☐ Driver ☐ Passenger ☐ Front Seat ☐ Back Seat

Struck from: ☐ Behind ☐ Front ☐ Left Side ☐ Right Side

Number of people in vehicle: _____ Wearing seat belts? ☐ Yes ☐ No

Were you knocked unconscious? ☐ Yes ☐ No If yes, for how long? _____

In your own words, please describe the accident: _____

_____

_____

_____

What are your PRESENT complaints and symptoms? _____

_____

_____

_____

Have you ever been involved in an accident before? ☐ Yes ☐ No
If yes, please describe: Include dates, types of accidents and any injury (ies) received:

_____

Have you been treated by any other physician since the accident? ☐ Yes ☐ No

If yes, please list doctor's name and address: _____

What treatment did you receive? _____

Do you notice any activity restrictions as a result of this injury? ☐ Yes ☐ No

If yes, please describe: _____

_____

_____

_____

PATIENT SIGNATURE DATE

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PATIENT PAIN FORM

NAME: _____

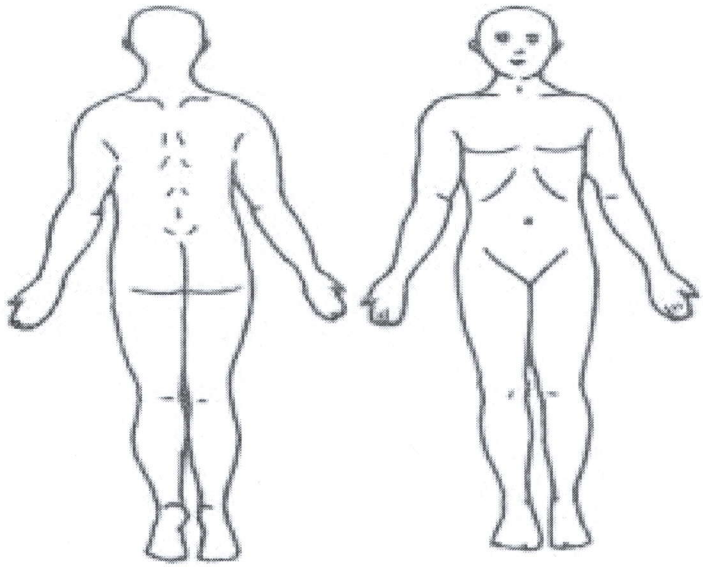
DATE SYMPTOMS OCCURRED: _____

Please circle the level of pain you currently have:

Pain Free 1 2 3 4 5 6 7 8 9 10 **Extreme Pain**

Using the symbols below, mark on the pictures where you feel the described sensations:

Numbness	===
Dull Ache	000
Burning	xxx
Sharp, stabbing	///
Pins, needles	+++
Other	...



_____

PATIENT'S SIGNATURE Date

_____

Physician comments: