



Wellness Rhythms
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WellnessRhythms.com

Personal Injury Questionnaire

Dear Patient, in our efforts to better serve you, please complete the following questionnaire and return it to the office. Thank you!

Name: _____ DOB: _____ Age: _____
Address: _____ City: _____ State: _____ Zip Code: _____
Phone: (home) _____ (work) _____ (cell) _____
Email Address: _____
Employer: _____ Phone: _____
Employer Address, City, State, Zip: _____
Date of Injury: _____ Location: _____
Your Auto Ins. Co.: _____ Agent: _____ Policy#: _____
Driver/Other Party: _____ Auto Ins. Co.: _____ Policy#: _____

Is there an attorney involved?

If yes, Name: _____ Phone: _____

Address: _____

Were there any witnesses?

If yes, Names: _____

Nature of Accident

What time of day did the accident take place? _____

What type of vehicle were you in? _____

What type of vehicle did the other party have? _____

Were you (check one):

() Driver () Passenger () Front Seat () Back Seat

Number of people in your vehicle? _____ Other Vehicle? _____

Was your vehicle struck from (check one):

() Behind () Front () Left Side () Right Side

Did you become unconscious?

Were the police notified?

If yes, incident report # if you have it: _____

In your own words, please describe the accident in detail: _____

Did you have any physical complaints **BEFORE THE ACCIDENT**?

If yes, please explain in detail: _____

Please describe how you felt:

DURING THE ACCIDENT: _____

LATER THAT DAY: _____

THE NEXT DAY: _____

What are your PRESENT complaints and symptoms? _____

Do you have any congenital (from birth) factors or any previous illnesses which relate to this accident?

If yes, please explain: _____

Have you been in any previous accidents?

If yes, please explain including dates, type of accident and any injuries sustained: _____

Where were you taken after your current accident? _____

Have you been treated by any other doctors for this accident?

If yes, please list names, address and the type of treatment you received: _____

Since the injury occurred, are you symptoms (check one):

Improving

Getting Worse

Same

Have you lost time from work as a result of this accident?

If yes, last date worked: _____

Are you being compensated for your lost time?

What type of compensation are you receiving? _____

Do you notice any activity restrictions as a result of this injury?

If yes, please explain: _____

Do you have any other pertinent information to provide relating to this injury? _____

Signature: _____ Date: _____