Auto Injury Questionnaire

BOURLAND CHIROPRACTIC CLINIC
1623 SE Enterprise Circle
Hillsboro, OR 97123

Date:_____

Patient Name:_____

Address:_____

Phone: Home:_____ Cell:_____ Work:_____

DOB: (m/d/y) _____Age:_____ Date of Accident:_____ Time of accident:_____am / pm

PIP Claim Number:_____

Your Insurance Company:_____ Phone:_____

Have you retained an attorney: Yes No
If yes, name of attorney:_____ Phone:_____

**Please describe the accident in your own words:**

**The following questions pertain to YOU and the vehicle you were in:**
**Make and Model:** _____ **Year**:_____
**Vehicle type (please circle one):** Car Van SUV Station Wagon Commercial Truck
Other_____
**Vehicle size:** Subcompact Compact Mid-size Large Car Small Pick-up Large Pick-up Small SUV
Large SUV Other_____
**Your position in the vehicle:** Driver Passenger If passenger, where were you seated:_____
**Speed of your vehicle**:_____
**If stopped or slowing, reason:** (circle one) Traffic Signal Stop Sign Pedestrian Parking Traffic
Other:_____
**Collision type:** Front Impact Rear Impact Side Impact
**If side impact:** Driver's side or Passenger's side
Front side Middle Rear side

**The following questions pertain to the OTHER vehicle(s) involved:**
**Make and Model:** _____ **Year**:_____
**Vehicle type (please circle one):** Car Van SUV Station Wagon Commercial Truck
Other_____
**Vehicle size:** Subcompact Compact Mid-size Large Car Small Pick-up Large Pick-up Small SUV
Large SUV Other_____
**Speed of other vehicle:**_____
**If stopped or slowing, reason:** (circle one) Traffic Signal Stop Sign Pedestrian Parking Traffic
Other:_____
**Collision type:** Front Impact Rear Impact Side Impact
**If side impact:** Driver's side or Passenger's side
Front side Middle Rear side

**Road Conditions at the time of the Accident:**

**Road/Street Name(s):**_____ **City/State:**_____
**Road conditions:** Dry Damp Wet Snow Covered Ice Covered Patchy Ice/Snow Other_____
**Visibility compromised?** No Brightness Darkness Rain Snow Fog Other_____

BOURLAND CHIROPRACTIC CLINIC
1623 SE Enterprise Circle
Hillsboro, OR 97123

**The following questions pertain to the moment of IMPACT of the accident:**

**At the moment of impact, you were:**
Totally unaware that the accident was impending_____ Aware that the accident was impending_____ Aware that the accident was impending and braced for it_____

**If you were the driver of the vehicle, was your foot on the brake pedal?**
Yes____ No____ Knocked off by impact____

**Were both hands on the steering wheel?**
Yes____ No____ If no, which hand was on the steering wheel? Left____ Right____

**Were you wearing your seatbelt?**
Yes____ No____ If yes, what type? Shoulder____ Lap____

**Was your vehicle equipped with air bags?**
Yes____ No____ If yes, was it/were they deployed Yes____ No____

**Was your seat equipped with a headrest?**
Yes____ No____ If yes, what position was the headrest in: Low(below head)____ Middle(even with head)____ High(top of head)____

**Position of your HEAD at the time of impact?**
Facing straight ahead____ Tilted downward ____ Tilted upward____ Turned to the left____ Turned to the right____

**Was your head jolted?** Yes____ No____
**If yes, in which direction?** Backward then forward____ Forward then backward ____ To the left ____ To the right____ Left then right____ Right then left

**Position of your BODY at the time of impact?**
Facing straight ahead ____ Tilted downward ____ Tilted upward____ Turned to the left____ Turned to the right____

**Was your body jolted?** Yes____ No____
**If yes, in which direction?** Backward then forward ____ Forward then backward ____ To the left ____ To the right ____ Left then right ____ Right then left____

**As a result of the collision, which objects in the vehicle did your body strike:**

**Head: circle all that apply**
· Steering wheel · Headrest· Air bag · Front of seat· Dashboard · Back of seat· Windshield· Rear view mirror
· Right door· Console· Left door· Gear shift· Right window· Armrest· Left window

**Left Arm: circle all that apply**
· Steering wheel · Headrest· Air bag · Front of seat· Dashboard · Back of seat· Windshield· Rear view mirror
· Right door· Console· Left door· Gear shift· Right window· Armrest· Left window

**Right Arm: circle all that apply**
· Steering wheel · Headrest· Air bag · Front of seat· Dashboard · Back of seat· Windshield· Rear view mirror
· Right door· Console· Left door· Gear shift· Right window· Armrest· Left window

BOURLAND CHIROPRACTIC CLINIC
1623 SE Enterprise Circle
Hillsboro, OR 97123

**Torso: circle all that apply**

· Steering wheel · Headrest · Air bag · Front of seat · Dashboard · Back of seat · Windshield · Rear view mirror

· Right door · Console · Left door · Gear shift · Right window · Armrest · Left window

**Left Leg: circle all that apply**

· Steering wheel · Headrest · Air bag · Front of seat · Dashboard · Back of seat · Windshield · Rear view mirror

· Right door · Console · Left door · Gear shift · Right window · Armrest · Left window

**Right Leg: circle all that apply**

· Steering wheel · Headrest · Air bag · Front of seat · Dashboard · Back of seat · Windshield · Rear view mirror

· Right door · Console · Left door · Gear shift · Right window · Armrest · Left window

**The following questions pertain to the time period IMMEDIATELY FOLLOWING the accident:**

**Did you lose consciousness?** Yes____ No_____ **If yes, how long you were unconscious?**_____

**Immediately following the accident, did you feel...? circle all that apply**

· Dizzy · Dazed · Disoriented · Weak · Nervous · Nauseated

**Were you able to walk unaided?**

· Yes · No

**Where did you go?**

· Drove home · Was driven home · Drove to hospital · Was driven to hospital · Taken to hospital by ambulance

· Drove to work · Was driven to work · Drove to school · Was driven to school · Other:

**In what areas did you IMMEDIATELY feel pain? Circle all that apply**

Head Neck Upper back Mid back Ribs Chest Abdomen Low back Pelvis

Shoulder · Left · Right Arm · Left · Right Elbow · Left · Right

Wrist · Left · Right Hand · Left · Right Fingers on · Left (Hand) · Right (Hand)

Buttock · Left · Right Hip · Left · Right Thigh · Left · Right

Knee · Left · Right Calf · Left · Right Ankle · Left · Right

Foot · Left · Right Toes on · Left (Foot) · Right ( Foot )

**In what areas did you experience lacerations (cuts) or contusions (bruises)?**

Head Neck Upper back Mid back Ribs Chest Abdomen Low back Pelvis

Shoulder · Left · Right Arm · Left · Right Elbow · Left · Right

Wrist · Left · Right Hand · Left · Right Fingers on · Left (Hand) · Right (Hand )

Buttock · Left · Right Hip · Left · Right Thigh · Left · Right

Knee · Left · Right Calf · Left · Right Ankle · Left · Right

Foot · Left · Right Toes on · Left (Foot ) · Right (Foot)

BOURLAND CHIROPRACTIC CLINIC
1623 SE Enterprise Circle
Hillsboro, OR 97123

**In what areas did you experience symptoms on the day(s) FOLLOWING the accident?**

Head Neck Upper back Mid back Ribs Chest Abdomen Low back Pelvis

Shoulder · Left · Right Arm · Left · Right Elbow · Left · Right
Wrist · Left · Right Hand · Left · Right Fingers · Left Hand · Right Hand
Buttock · Left · Right Hip · Left · Right Thigh · Left · Right
Knee · Left · Right Calf · Left · Right Ankle · Left · Right
Foot · Left · Right Toes · Left Foot · Right Foot

**The day after the accident, your symptoms were:**

Better · Worse · Same

**Did you go to the hospital at any time since the accident?**
Yes No If yes, when?_____ Name of hospital_____-

**At the hospital, were x-rays taken? If yes, what areas were x-rayed?**

Head Neck Upper back Mid back Ribs Chest Abdomen Low back Pelvis

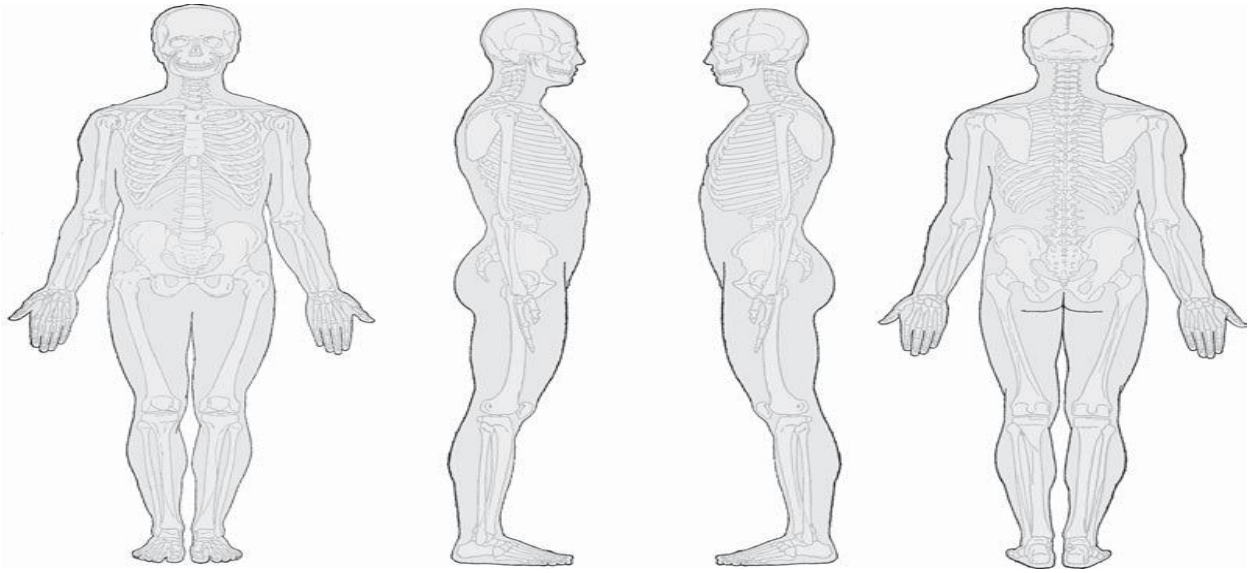
Shoulder · Left · Right Arm · Left · Right Elbow · Left · Right
Wrist · Left · Right Hand · Left · Right Fingers · Left · Right
Buttock · Left · Right Hip · Left · Right Thigh · Left · Right
Knee · Left · Right Calf · Left · Right Ankle · Left · Right
Foot · Left · Right Toes · Left · Right

**Treatment received at hospital?**_____

_____

**Using the diagram and key, please draw where you are experiencing symptoms**

1. Achy, Dull, Sore
2. Stiffness, Tightness
3. Sharp Stabbing
4. Sharp Shooting
5. Numbness, Tingling
6. Burning
7. Throbbing
8. Swelling
9. Snapping, Popping, Grinding
10. Other _____



BOURLAND CHIROPRACTIC CLINIC
1623 SE Enterprise Circle
Hillsboro, OR 97123

**Please rate the current severity of your pain symptoms:** (0=no pain : 10=unbearable)

• 0• 1• 2• 3• 4• 5• 6• 7• 8• 9• 10

**Compared to onset, are your symptoms:** • Better • Worse • Same

**Do your symptoms prevent you from getting to sleep?** • Yes • No **Wake you at night?** • Yes • No

**Are your activities of daily living affected?** (e.g. difficulty performing work duties, getting dressed, etc.) • Yes • No
If so, please explain_____

_____

**Have you lost time from work as a result of this accident?** YES NO
**If yes, last day worked?**_____

**Please list any medications you are presently taking: (include vitamins)**

**Did you have any physical complaints BEFORE THE ACCIDENT?** YES NO
**If yes, please describe in detail:**

**Have you ever been involved in an accident before?** YES NO
**If yes, please describe, including date(s) and type(s) of accidents, as well as injuries received.**

**By signing below, I certify that the information in this document is full and complete to the best of my knowledge:**

Signature:_____ Date:_____
(parent/guardian if under 18)