Raschke Chiropractic Center, S.C.
Preventive Family Health Care
Fred W. Raschke, D.C.

PERSONAL INJURY QUESTIONNAIRE

PERSONAL INFORMATION

Name: _____ _____Phone: ( )_____
Address: _____ City: _____ State: _____ Zip: _____
Age: _____ Birthdate: _____ Sex: _____ SSN#: _____
Marital Status: M _____ S _____ W _____ D _____
Habits:
Smoke: _____ None _____ Pack(s) a day _____ How many years?
Alcohol: _____ Never _____ Social _____ Light _____ Moderate _____Heavy
Employer's name: _____Position: _____ Phone: ( )_____
Address: _____ City: _____ State: ____ Zip: _____

INSURANCE INFORMATION

Your ins. Co.: _____ Policy#: _____ Agent name: _____
Address: _____ City: _____ State: _____ Zip: _____
Name on policy (if other than self): _____ Policy#: _____
Responsible Party's name: _____
Address: _____ City: _____ State: _____ Zip: _____
Policy holder's name: _____ Policy#: _____

ATTORNEY

Name: _____ Phone: ( )_____
Address: _____ City: _____ State: _____ Zip: _____

INJURY HISTORY

Date of injury _____
Was the crash on-the-job? _____ Yes _____ No
You were: _____Driver _____Front seat passenger _____Rear seat passenger _____Motorcycle rider
_____Motorcycle passenger _____Other
Vehicle driven by: _____Your vehicle (make, model, year): _____
Your estimated speed at moment of crash: _____ _____ Stopped _____ Slowing _____Accelerating
Other vehicle (year, make, model): _____
Were you struck from: _____ Behind _____ Front _____ Left side _____Right side
Time of day: _____ Daylight _____ Dawn _____ Dusk _____ Dark
Road conditions: _____ Dry _____ Damp _____ Wet _____ Snow _____ Ice _____ Other
Head restraints: ____None ____Integral type ____Adjustable up ____Adjustable down ____Don't know
If adjustable, was the position altered by the crash? _____ Yes _____ No
Was the seat back adjustment altered by the crash? _____ Yes _____ No
Was the seat broken? _____ Yes _____ No
Lap belt: _____Wearing one _____ Not wearing one _____ Don't know
Shoulder belt: _____ None _____ Wearing one _____Not wearing one _____Don't know
Did airbag deploy? _____ Yes _____ No If yes, were you struck? _____ Yes _____ No
Body position: _____ Good _____ Forward lean _____ Other
Head position: _____ Hands: _____ One on wheel _____ Two on wheel _____ N/A

Crash description: _____
_____
_____
_____

Crash diagram: Aware of impending crash? _____ Yes _____ No

During the crash:

Did you strike any parts of the vehicle? __Y __N If yes, describe: _____
Did vehicle strike any objects after crash? __Y __N If yes, describe: _____
Wearing hat or glasses? _____ Yes _____ No If yes, still on after crash? _____ Yes _____ No
Did you lose consciousness? _____ Yes _____ No If yes, for how long? _____
Estimated property damage to your vehicle: $_____
Estimated damage to other vehicle: _____ None _____ Minimal _____Moderate _____Major
Were the police on-scene? _____ Yes _____ No If yes, was a report made? _____ Yes _____ No

After the crash:

Symptoms: _____ Headache _____ Dizziness _____ Nausea _____ Confusion/disorientation
_____ Neck pain _____ Paresthesia(s). If yes, where? _____
_____ Back pain _____ Extremity pain. If yes, where? _____
When did symptoms first appear? _____ Immediately ___ Hr(s) afterward. What symptom? _____
Where did you go after the crash? _____ Home _____Work _____ Hospital
Mode of transportation: _____ Private Dr.: _____

Emergency department:
Radiographs: _____ Yes _____ No Body parts imaged: _____
Results: _____
Lab work: _____ Yes _____ No _____Cervical collar _____Ice
Medications: _____ Other: _____
Follow up instructions: _____
_____
_____

Did you have any physical complaints BEFORE THE ACCIDENT? _____ Yes _____ No
If yes, please describe in detail (include any medications): _____
_____
_____
Have you ever been involved in an accident before? _____ Yes _____ No

CURRENT MEDICAL HISTORY

Please list all **medications** that you presently take (prescription & non-prescription)

Medication	Strength	Frequency

Please list any nutritional supplements that you are presently take:

_____
_____
_____
_____

Allergies: **Yes or No**

Medicine: _____ Severity: mild mod severe Reaction: _____
Medicine: _____ Severity: mild mod severe Reaction: _____
Medicine: _____ Severity: mild mod severe Reaction: _____
Food: _____ Severity: mild mod severe Reaction: _____
Environmental: _____ Severity: mild mod severe Reaction: _____

MEDICAL HISTORY

Surgeries (dates and residuals): _____
_____
_____

Fractures (dates and residuals): _____
_____
_____

Serious illness (dates and residuals): _____
_____
_____

Workman's Compensation Injuries (date, treatment, awards, residuals):
_____
_____
_____

Personal Injuries (date, treatment, awards, residuals):
_____
_____
_____

Sports or other injuries to head, neck, or back: _____
_____
_____

Any prior history of current complaints:
1. _____
2. _____
3. _____

Prior treatment by chiropractor for these:
1. _____
2. _____
3. _____

Past Medical History

Have you been diagnosed with any other medical problems? (Check all that apply)

___ High blood pressure	___ Seizures	___ Easy bleeding
___ Diabetes	___ Tuberculosis	___ Blood clots
___ Cancer	___ Emphysema or asthma	___ Depression
___ Rheumatoid arthritis	___ Heart attack or angina	___ Anxiety disorder
___ Arthritis	___ Irregular heart beat	___ Mental illness
___ Gout	___ Abnormal heart valve	___ Addiction to alcohol / drug
___ Thyroid disease	___ Aortic aneurysm	___ HIV/AIDS
___ Tension headaches	___ Poor circulation	___ Major trauma (accidents, falls)
___ Migraine headaches	___ Ulcers in stomach or intestines	___ Broken bones
___ Stroke or TIA	___ Kidney problems	___ Severe head injury
___ Liver problems	___ Osteoporosis	___Bowel problems
___Sleep apnea	___Insomnia	___Chronic Fatigue
___ Brain aneurysm	___Lyme's Disease	___Digestive problems

___ Other _____

Red flag check list for over 50

___Prolonged Corticosteroid use	___Unexplained weight loss	___Pain that does not improve with rest
___Progressive weakness in legs	___Urinary retention or incontinence	___Failure to respond to previous care
___None of these apply		

Family History

What diseases run in your family? Father(**F**) Mother(**M**) Brother(**B**) Sister(**Si**) Son(**S**) Daughter(**D**) Unknown(**U**)

_____ Diabetes _____ Cancer _____ Heart disease _____ Stroke
_____ Depression _____ Reaction to anesthesia _____ Arthritis_____ Rheumatoid Arthritis _____
High Blood Pressure_____ Other _____ Unknown_____

Education & Occupation Information

How many years of school did you complete? _____
What is your job title? _____ Are you: ( ) Full-time ( ) Part-time
How many hours per day do you work? _____ Days per week? _____
How long have you worked at your present job? _____Years _____Months
Does your job require you to frequently lift objects? Yes No
If yes, what is the heaviest load frequently lifted? _____
What is your primary work position? _____
Does work aggravate your present complaint? Yes No
Is there anything else you would like us to know about your health? Yes No
If yes, please explain_____
_____

I acknowledge that I have been given a copy of the *Notice of Privacy Practices* document on _____ (date),
_____ (signature)

Thank you for completing this questionnaire. Guardian's signature is required if under 18 years of age. Signature implies consent to treatment.

_____ _____
Signature Date

_____ _____
Doctor's Signature Date