Dr. Russell T. Elba, Chiropractor D/B/A **Protect Your Spine** • Sheridan Professional Plaza 4050 Sheridan Street, Suite C • Hollywood, FL 33021
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PERSONAL INJURY QUESTIONAIRE (Page 1 of 2)

First Name: _____ M.I._____ Last Name: _____ D.O.B._____ Age_____ Sex: M / F

Address: _____ City:_____ State_____ Zip:_____

Phone: Home _____ Cell:_____ Email:_____

SSN:_____ Employer's Name:_____ Employer's Phone:_____

Employer's Address: _____

Insurance Name:_____ Policy #:_____ Agent's Name:_____

NATURE OF ACCIDENT:

Date of Accident: _____ Time of Day: _____ Number of people in your vehicle: _____ Were the police notified? ❑ Yes ❑ No

Your seat: ❑ Driver ❑ Passenger ❑ Back Driver ❑ Back Passenger Did you lose consciousness? ❑ Yes ❑ No If yes, how long? _____

What direction were you headed? ❑ North ❑ East ❑ South ❑ West on (Name of street):_____

What direction was the other car headed? ❑ North ❑East ❑ South ❑ West on (Name of street):_____

Where were you struck? ❑ Behind ❑ Front ❑ Left Side ❑ Right Side Approximate speed of your car _____mph Other car _____mph

In your own words, please describe accident: _____

Did you have any physical complaints BEFORE the accident? ❑ Yes ❑ No If yes, please describe in detail: _____

What are you present complaints and symptoms? _____

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PERSONAL INJURY QUESTIONAIRE (Page 2 of 2)

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 injury(ies) received: _____

_____

_____

Where were you taken after the accident? _____

Have you been treated by another doctor since the accident? ❑ Yes ❑ No If yes, please list doctor's name and address: _____

_____

What type of treatment did you receive? _____

_____

Since the injury occurred, your symptoms are? ❑ Improving ❑ Getting Worse ❑ The Same

CHECK SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT:

❑ Headache	❑ Irritability	❑ Numbness in Toes	❑ Face Flush	❑ Feet Cold
❑ Neck Pain	❑ Chest Pain	❑ Shortness of Breath	❑ Buzzing in Ears	❑ Hands Cold
❑ Stiff Neck	❑ Dizziness	❑ Fatigue	❑ Loss of Balance	❑ Stomach Upset
❑ Sleeping Problems	❑ Head Seems Too Heavy	❑ Depression	❑ Fainting	❑ Constipation
❑ Back Pain	❑ Pins & Needles in Arms	❑ Lights Bother Eyes	❑ Loss of Smell	❑ Cold Sweats
❑ Nervousness	❑ Pins & Needles in Legs	❑ Loss of Memory	❑ Loss of Taste	❑ Fever
❑ Tension	❑ Numbness in Fingers	❑ Ears Ring	❑ Diarrhea	❑ Other

Symptoms other than listing above: _____

Have you lost time from work as a result of this accident? ❑ Yes ❑ No If yes, please complete this question:

1. Last day worked: _____
2. Type of employment: _____

Did you notice any activity restrictions as a result of this injury? ❑ Yes ❑ No If yes, please describe in detail: _____

_____

_____

_____

_____

_____

X _____ Date: _____

(Signature of patient or parent / guardian of minor)