Albuquerque Alternative Health Personal Injury Questionnaire

Patient Information File#:

Legal Name: (Last) _____ (First) _____ (Middle Initial) _____

Email: _____ Primary Phone: _____ ☐ Home ☐ Cell ☐ Work

Address: _____ City: _____

State: _____ Zip: _____

Insurance/ Lawyer Information

Date of Accident: _____

YOUR INSURANCE:

Claim Number: _____

Your Insurance Company: _____ Policy Number: _____

Adjusters Name: _____ Phone Number: _____

OTHER PARTY'S INSURANCE:

Claim Number: _____

Other Party's Insurance Company: _____ Policy Number: _____

Adjuster's Name: _____ Phone Number: _____

Have you retained an attorney? ☐ Yes ☐ No If yes, attorneys name: _____

Phone Number: _____

Additional Notes: _____

_____

Accident Information

Date of Accident: _____ Time of Day: _____ ☐ AM ☐ PM

Were you: ☐ Driver ☐ Passenger ☐ Front Seat ☐ Back Seat

Number of people in the vehicle: _____ Number of people in other vehicle: _____

Road conditions at time of the accident: ☐ Wet ☐ Dry ☐ Other: _____

Were you struck from: ☐ Behind ☐ Front ☐ Left Side ☐ Right Side

Were you wearing a seatbelt? ☐ Yes ☐ No

If yes: ☐ Lap belt only ☐ Shoulder & Lap Belt ☐ Shoulder only

Did you sustain any bruising or soreness from the seatbelt? ☐ Yes ☐ No

If yes, please explain: _____

What was your position at the time of impact? ☐ Facing forward ☐ Head Turned ☐ Left Side ☐ Right Side

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

Were you aware of the approaching collison prior to impact? ☐ Yes ☐ No

Was your car stopped at the time of impact? ☐ Yes ☐ No

If Yes: Was the drivers foot on the brake pedal? ☐ Yes ☐ No

Did your car move forward upon impact? ☐ Yes ☐ No

If No: Were you: ☐ Gaining Speed ☐ Slowing down ☐ Traveling the speed limit ☐ Driving Slow ☐ Driving Fast

Accident Information Cont.

Did your vehicle strike another vehicle? ☐ Yes ☐ No

Did your vehicle strike another object? ☐ Yes ☐ No If yes, What? _____

Was the other vehicle moving at the time of the collision? ☐ Yes ☐ No

If yes, was the vehicle traveling: ☐ Slow ☐ Medium ☐ Fast

And ☐ Gaining Speed ☐ Slowing down ☐ Traveling steadily

Make and model of your vehicle: _____

Make and model of other vehicle: _____

Describe the accident, including what you saw, heard and/or felt: _____

_____

_____

Describe how you felt: _____

Did you feel pain? ☐ Yes ☐ No If yes, what? _____

Immediately after the accident: _____

Later that day: _____

The next day: _____

What was the estimated cost of damage to your vehicle? _____

Do you have photos of the damage? ☐ Yes ☐ No

On what part of the automobile did the following body parts hit:

Head: _____ Chest: _____ Right/Left Arm: _____

Right/Left Hip: _____ Right Left Shoulder: _____ Right/Left Knee: _____

Right/Left Leg: _____ Other: _____

Did the air bag(s) deploy? ☐ Yes ☐ No If yes, what part of your body hit the air bag? _____

Did it leave a bruise? ☐ Yes ☐ No

Which of the following parts broke during the accident: ☐ Windsheild ☐ Right/Left Side Window ☐ Steering Wheel

☐ Front/ Back Seat ☐ Other(s): _____

What are your PRESENT complaints and symtoms: _____

_____

Have you ever been involved in an accident before? ☐ Yes ☐ No

If yes, please describe: _____

Did you receive any medical care following the accident? ☐ Yes ☐ No

If yes, please describe: _____

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

What type of treatment? _____

Since this injury occurred, are your symptoms: ☐ Improving ☐ Getting Worse ☐ Same

Please check off all symptoms: (Check all that apply) ☐ Dizziness ☐ Difficulty Sleeping ☐ Jaw Problems

☐ Nausea ☐ Memory Loss ☐ Arm/Shoulder Pain ☐ Irritablilty ☐ Back Pain ☐ Headache(s)

☐ Numbness ☐ Fatigue ☐ Low Back Pain ☐ Blurred Vision ☐ Tensioni ☐ Chest Pain

☐ Back Stiffness ☐ Neck Pain ☐ Shortness of Breathe ☐ Other: _____