WholeCare Personal Injury Questionnaire

Name ____ Date ________________ Phone___________________
Address____ City_____________ State ___ Zip ________
Date of Accident ___ / ___ / ___ Approx. Time ________ Was the Accident: Auto-Related Slip and/or Fall Other
Please Describe the Accident ____
____
If an auto accident, were the police notified? Yes No Was a report made? Yes No
Please Describe Your Physical Condition:

During the accident: ____
Immediately after the accident: ____
Later that day: ____
The *next* day: ____

What Are Your Present Complaints and Symptoms? ____
____
Were You Knocked Unconscious? Yes No *Were You*: Driving Passenger *In The:* Front Seat Back Seat
Were You Wearing Your Seatbelt? Yes No *Number of People in the Vehicle*: ___ *In the Other Vehicle*? ___
Were You Struck From: Behind Front Left Side Right Side *Did Your Airbag Deploy?* Yes No
Have You Been Treated by *another* Doctor Since the Accident? Yes No If yes, what type of treatment did you receive? ____
Since the Injury Occurred, Are Your Symptoms: Improving Same Getting Worse
Do You Notice Any Activity Restrictions as a Result of this Injury? ______________________________
____

Circle All That Apply:

Headache	Light Sensitivity	Sleeping Problems	Fatigue	Tension
Irritability	Nervousness	Depression	Memory Loss	Loss of Balance
Neck Pain	Head feels heavy	Stiff Neck	Buzzing in Ears	Ringing in Ears
Fever	Face Flushed	Cold Sweats	Diarrhea	Constipation
Back Pain	Chest Pain	Shortness of Breath	Numb Hands/Feet	Cold Hands/Feet
Loss of Smell	Loss of Taste	Pins and Needles in Arm or Legs		Fainting

Symptoms Other Than Above: ____
____

I understand ***and*** accept that Whole*Care*, Inc. ***will not be participating*** in any insurance or legal issues that may arise from my accident and that I am responsible for payment at time of service.

Patient Signature ____ Date ___/___/_____