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PERSONAL INJURY QUESTIONNAIRE

Name _____ Date _____

Address _____ Postal Code _____

Date of Birth _____ Occupation _____

Your Insurance Company _____ Have you retained an attorney _____

Date of Accident _____ Driver's Name/Other Vehicle _____

Were you: Driver Passenger Front Seat Back Seat Other

What direction were you headed _____

What direction was the other vehicle headed _____

Were you struck from Behind Front Left Side Right Side

Which direction were you facing on impact _____

Were you aware you were about to be hit _____

Were you knocked unconscious _____ If yes for how long _____

In your own words please describe the accident _____

Did you have any complaints BEFORE THE ACCIDENT _____ If yes please describe. _____

Please describe how you felt:

DURING the accident _____

IMMEDIATELY AFTER the accident _____

LATER THAT DAY _____

THE NEXT DAY _____

Have you been examined or have you received treatment since the accident _____

What are your present complaints and symptoms _____
