Jeffrey E. Poplarski, D.C.
Patient Information Sheet

217 Merrick Rd.
Suite 204
Amityville, NY 11701
Tel. (631) 598-7034
Fax (631) 598-7479

CAR ACCIDENT / NO-FAULT
PERSONAL INJURY QUESTIONNAIRE

Name:_____ D.O.B._____ Phone:_____
Address_____City_____State_____Zip_____
Employer's Name_____ Address_____ Phone_____
Your Ins Co._____ Address_____ Phone_____
Address_____ Phone _____
Agents name_____ Driver/other Vehicle_____
Insur Co. _____Policy #_____
Have you retained an attorney: ( ) Yes ( )No
Name_____Address_____
_____ Phone _____

NATURE OF ACCIDENT:

- Date of Accident_____ Time of Day_____
- Were you the ( )Driver ( ) Passenger ( ) Front Seat ( ) Back Seat
- Number of people I your vehicle_____ Other vehicle_____
- What direction were you headed? ( )North( )South( ) East( )West How fast?_____
  Name of street or intersection_____
- Were you struck from: ( ) Behind ( )Front ( )Left side ( )Right side
- Were you knocked unconscious? ( ) yes ( ) No If yes, for how long? _____
- Were you wearing your seat belt? ( ) yes ( ) no
- Were the police notified? ( )yes ( ) no
- In your own words, please describe the accident:

  _____
  _____
  _____
  _____

- Did you have any physical complaints **BEFORE** the accident?

  _____
  _____
  _____
  _____

- Please describe how you felt;
  During the accident: _____
  Immediately after the accident_____
  Later that day: _____
  The **next** day:_____
- What are your present symptoms?

  _____
  _____

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- Do you have any congenital (from birth) factors, which relate to this problem?
- ( ) yes ( ) No If yes, please describe:

- Do you have any previous illnesses, which relate to this case? ( ) yes ( )no If yes, please describe:

- Have you been involved/injured in an accident before? ( ) yes ( ) no If yes, please describe including dates and type of accident as well as attending doctor:

- Where were you taken after the accident?

- Have you been treated by another doctor since the accident? ( ) yes ( ) no If yes, please give name and address:

- Have you lost time from work as a result of this accident ( ) yes ( ) No If yes, please complete the following:

  Last day worked: _____
  Type of employment: _____
  Present Salary**:** _____
  Are you being compensated for time lost from work? ( ) yes ( ) No If yes, please state the type of compensation you are receiving**:** _____

- Do you notice any activity restrictions as a result of this injury? ( ) yes ( ) No
- If yes, please describe in detail:

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- Other pertinent information:

  _____
  _____
  _____
  _____

CHECK SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT

- ❑ Headache
- ❑ Neck Pain
- ❑ Stiff neck
- ❑ Sleeping problems
- ❑ Back pain
- ❑ Nervousness
- ❑ Tension
- ❑ Irritability
- ❑ Chest Pain
- ❑ Dizziness
- ❑ Head Seems too heavy
- ❑ Pins & Needles in arms
- ❑ Pins & Needles in legs
- ❑ Numbness in Fingers
- ❑ Numbness in toes
- ❑ Shortness of Breath
- ❑ Fatigue
- ❑ Depression
- ❑ Lights bother eyes
- ❑ Loss of Memory
- ❑ Ears Ringing
- ❑ Face Flushed
- ❑ Buzzing in Ears
- ❑ Loss of Balance
- ❑ Fainting
- ❑ Loss of Smell
- ❑ Loss of Taste
- ❑ Diarrhea
- ❑ Feet Cold
- ❑ Hands Cold
- ❑ Stomach Upset
- ❑ Constipation
- ❑ Cold Sweats
- ❑ Fever
- ❑ _____