Atlas Sports Fitness and Rehab
Personal Injury Questionnaire

4025 Brandon Gate Dr, Suite 2, Mississauga
905-677-3945 mailbox@asfrcare.ca

Name_____ Date_____

Address_____APT #_____ Home (_____

City_____Prov_____Postal Code_____ Cell ( )_____

Birth date D_____M_____Y_____ Sex_____ Email_____ Bus. ( )_____

Ins Co._____ Claim#_____

Policy holder's Name (if other than you)_____ Policy #_____

LEGAL REPRESENTATIVE

Name_____ Phone( )_____Fax( )_____

Address_____City_____Prov_____PC_____

NATURE OF ACCIDENT

1. Date of Accident D_____M_____Y_____ Time of Day_____
2. Were you: ( )Driver ( ) Passenger ( )Front Seat ( ) Back Seat
3. Number of people in your vehicle? _____ Were you wearing your seat belt?_____
4. What direction were you headed? ( )North ( )East ( )South ( )West
   On (name of street)_____
5. What direction was the other vehicle headed? ( )North ( )East ( )South ( )West
   On (name of street)_____
6. Were you struck from: ( )Behind ( )Front ( )Left Side ( )Right Side
7. Approximate speed of your car _____km/h Other car _____km/h
8. Were you knocked unconscious? ( ) Yes ( ) No If yes, for how long?_____
9. Were there any witnesses? ( ) Yes ( ) No Were police notified? ( ) Yes ( ) No
10. Did an ambulance arrive at the accident? ( ) Yes ( ) No
    If yes, were you taken to the hospital? ( ) Yes ( ) No For how long?_____
11. In your own words, please describe the accident:_____
    _____
    _____
    _____
    _____
12. Please describe how you felt:
    a. **IMMEDIATELY AFTER** the accident: _____
    b. **LATER** THAT day: _____
    c. **NEXT** day: _____
13. What are your **PRESENT** complaints and symptoms? _____
    _____

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14. CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT:

__ Headache	__ Irritability	__ Numbness in Toes	__ Face Flushed	__ Feet Cold
__ Neck Pain	__ Chest Pain	__ Shortness of Breath	__ Buzzing in Ears	__ Hands Cold
__ Neck Stiff	__ Dizziness	__ Fatigue	__ Loss of Balance	__ Upset Stomach
__ Sleep Problems	__ Head is Heavy	__ Depression	__ Fainting	__ Constipation
__ Back Pain	__ Pins/Needles (Arm)	__ Lights Bother Eyes	__ Loss of Smell	__ Cold Sweats
__ Nervousness	__ Pins/Needles (Leg)	__ Loss of Memory	__ Loss of Taste	__ Fever
__ Tension	__ Numbness/Fingers	__ Ears Ringing	__ Diarrhea	

Symptoms other than above_____

15. Since the accident occurred, are your symptoms: ( ) Improving ( ) Worse ( ) Same

16. Have you been treated by another doctor since the accident? ( ) Yes ( ) No

If yes, what type of treatment did you receive and please give the doctor's name: _____

_____

_____

17. Type/Title of employment: _____

a. Have you lost time from work as a result of this accident? ( ) Yes ( ) No

b. If yes to above, what was the last day you worked: _____

18. Did you notice any activity restrictions as a result of this injury? ( ) Yes ( )No If yes, give details

_____

_____

19. Do you have any restrictions in respect to care-giving, housekeeping/maintenance, and self care?

_____

_____

PAST HISTORY

20. Did you have any physical complaints BEFORE THE ACCIDENT? ( ) Yes ( ) No If yes, give details

_____

_____

21. Do you have any family or birth factors which relate to this problem? ( ) Yes ( ) No If yes, give details

_____

_____

22. Do you have any previous illnesses that **DO NOT** relate to the accident? ( ) Yes ( ) No If yes, give details

_____

_____

23. Have you ever been involved in an accident before? ( ) Yes ( ) No If yes, please describe and provide date(s) and type(s) and injury(ies) received: _____

_____

_____

_____ _____

Patient Signature **Date (Day/Month/Year)**