Personal Injury Questionnaire

Name _____ Home Phone_____ Cell Phone_____
Address_____ City _____ State _____ Zip _____
Age ____ Birth Date _____ E-mail _____ Sex ____ S/S No._____
Employer's Name _____ Employer's Address_____
Your Auto Ins. Co. _____ Policy #_____ Agent's Name_____
Name on Policy (If Other than self)_____ Policy # _____
Responsible Party's Name _____
Address _____ City _____ State _____ Zip_____
Policy Holders' Name _____ Policy#_____

ATTORNEY INFO

Name _____ Phone ( ) _____
Address_____ City _____ State _____ Zip _____
Were there any witnesses? ( )Yes ( )No Name(s) _____

NATURE OF ACCIDENT:

1. Date of Accident:_____ Time of Day:_____
2. Were you: ( ) Driver ( ) Passenger ( ) Front Seat ( ) Back Seat
3. Number of people in your vehicle? _____ Were you wearing seat belts? _____
4. What direction were you headed? ( ) North ( ) East ( ) South ( ) West
   On (name of street) _____
5 . What direction was 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 _____mph Other car _____ mph
8. Were you knocked unconscious? ( ) Yes ( ) No If yes, for how long? _____
9. Were the police notified? ( ) Yes ( ) No If yes, please let us copy the Police Report.
10. In your own words, please describe accident: _____

_____

_____

_____

11. Did you have any physical complaints BEFORE THE ACCIDENT? ( ) Yes ( ) No If yes, please describe in detail:_____

_____

_____

12. Please describe how you felt:
    a. DURING the accident: _____
    b. IMMEDIATELY AFTER the accident: _____
    c. LATER THAT DAY: _____
    D. THE NEXT DAY: _____

13. What are your PRESENT complaints and symptoms? _____

_____

_____

14. Do you have any congenital (from birth) factors which relate to this problem? ( ) Yes ( ) No If yes, please describe: _____
15. Do you have any previous illnesses which relate to this case? ( ) Yes ( ) No If yes, please describe:

_____

_____

16. Have you ever been involved in an accident before: ( ) Yes ( ) No If yes, please describe, including date(s) and type(s) of accidents, as well as injury(ies) received._____
_____
_____

17. Where were you taken after the accident? _____

18. Have you been treated by another doctor since the accident? ( ) Yes ( ) No If yes, please list doctor's name and address: _____

What type of treatment did you receive? _____
_____

19. Since the injury occurred, are your symptoms: ( ) Improving ( ) Getting Worse ( ) Same

20. 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	□ Stomach Upset
□ Sleeping Problems	□ Head Seems Heavy	□ Depression	□ Fainting	□ Constipation
□ Back Pain	□ Pins & Needles in Arms	□ Lights Bother Eyes	□ Loss of Smell	□ Cold Sweats
□ Nervousness	□ Pins & Needles in Legs	□ Loss of Memory	□ Loss of Taste	□ Fever
□ Tension	□ Numbness in Fingers	□ Ears Ring	□ Diarrhea	□ _____

Symptoms Other Than Above _____

21. Have you lost time from work as a result of this accident? ( ) Yes ( ) No If yes, please complete this question.
   a. Last Day Worked: _____
   b. Type of Employment: _____
   c. Present Salary: _____
   d. Are you being compensated for time lost from work? ( ) Yes ( ) No If yes please state type of compensation you are receiving: _____

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

23. Other pertinent information: _____
_____

_____ _____
Date Patient's Signature