PERSONAL INJURY QUESTIONNAIRE

Name ____ Phone ( ) ____________________________

Address _________________________________ City _______________ State ___________ Zip ___________

Age _________ Birthdate ____________________ Sex ___________ S/S # ______________________________

Employer's Name ___________________________ Employer's Address _______________________________

Your Ins. Co. ____________________ Policy # ____________________ Agent's Name _____________________

Name on Policy (If other than self) _______________________________ Policy # _________________________

Responsible Party's Name ____

Address ___________________________________ City _____________ State _________ Zip ______________

Policy Holder's Name ____ Policy # _________________________

ATTORNEY

Name ____ Phone ( ) _____________________

Address __________________________________ City _____________ State __________ Zip ______________

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 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 ________mph Other Car ________mph
8. Were you knocked unconscious? ( ) Yes ( ) No If yes, for how long? _________________
9. Were police notified? ( ) Yes ( ) No
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) & type 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 & address: ____

What type of treatment did you receive? ____

19. Since this 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 Problem ☐ Head Seems Too Heavy ☐ Depression ☐ Fainting ☐ Constipation
☐ Back Pain ☐ Pins & Needles in Arms ☐ Light bothers 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. Las Day Worked: ____

B. Types 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