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 _____

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 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) 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 this injury occurred, are your symptoms: ( ) Improving ( ) Getting Worse ( ) Same

20. CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT:

☐ Headache	☐ Irritablity	☐ 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 Too 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

Name _____

1) Date of Accident ____ / ____ / ____ 2) Time of Accident ____ : ____ (AM / PM)

3) Were you: A) Driver B) Passenger (Front) C) Passenger (Rear) D) Pedestrian

4) Were you wearing seatbelts? (Y/N)

5) Type of Vehicle: A) Auto B) Truck C) Van D) Motorcycle E) Motorhome F) Bicycle

6) How accident occurred: A) Struck by another vehicle B) Struck another vehicle C) Struck a stationary object D) Other

7) Where was your vehicle hit?. A) Front B) Rear C) Rt. Side D) Lft. Side E) Rt. Front F) Lft. Front G) Rt. Rear H) Lft. Rear

8) Where was other vehicle hit? A) Front B) Rear C) Rt. Side D) Lft. Side E) Rt. Front F) Lft. Front G) Rt. Rear H) Lft. Rear

9) Your approximate speed ____ MPH 10) Other vehicle approximate speed ____ MPH

11) What occurred at the moment of impact? (Circle as many as apply)

A) Tensed body for impact B) Neck whipped forward & back C) Spine torqued and twisted D) Thrown over seat

E) Thrown from vehicle F) Pinned in vehicle G) Thrown from side to side H) Cut and bruised

12) Did you strike your: (Circle as many as apply)

A) Head	Against the: 1) Dashboard	2) Windshield	3) Steering Wheel	4) Rt. Door	5) Lft. Door	6) Seat Frame	7) Unknown Object	
B) Shoulder	(Lft./Rt.) - Against the: 1) Dashboard	2) Windshield	3) Steering Wheel	4) Rt. Door	5) Lft. Door	6) Seat Frame	7) Unknown Object	
C) Arm	(Lft./Rt.) - Against the: 1) Dashboard	2) Windshield	3) Steering Wheel	4) Rt. Door	5) Lft. Door	6) Seat Frame	7) Unknown Object	
D) Elbow	(Lft./Rt.) - Against the: 1) Dashboard	2) Windshield	3) Steering Wheel	4) Rt. Door	5) Lft. Door	6) Seat Frame	7) Unknown Object	
E) Wrist	(Lft./Rt.) - Against the: 1) Dashboard	2) Windshield	3) Steering Wheel	4) Rt. Door	5) Lft. Door	6) Seat Frame	7) Unknown Object	
F) Hip	(Lft./Rt.) - Against the: 1) Dashboard	2) Windshield	3) Steering Wheel	4) Rt. Door	5) Lft. Door	6) Seat Frame	7) Unknown Object	
G) Knee	(Lft./Rt.) - Against the: 1) Dashboard	2) Windshield	3) Steering Wheel	4) Rt. Door	5) Lft. Door	6) Seat Frame	7) Unknown Object	
H) Ankle	(Lft./Rt.) - Against the: 1) Dashboard	2) Windshield	3) Steering Wheel	4) Rt. Door	5) Lft. Door	6) Seat Frame	7) Unknown Object	

13) Were you rendered unconscious? (Y/N) 14) Did you receive medical attention at the scene of the accident? (Y/N)

15) Where did you go immediately following the accident? A) Hospital B) Home C) Personal Doctor D) To this office E) Resumed activities

16) Were you: (Circle as many as apply) A) Shaken B) Disoriented