

PERSONAL INJURY QUESTIONNAIRE

Name _____ Phone _____
 Address _____ City _____ State _____ Zip _____
 Age _____ Birth date _____ Sex _____ S/S# _____
 Your Ins. Co. _____ Agent's Name _____
 Name on Policy (if other than self) _____ Their Date of Birth _____
 Policy # _____ *Claim #* _____
 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 _____ *State Accident Occurred* _____
2. Were you Driver Passenger Front seat Back seat
3. Number of people in your vehicle? _____ Were you wearing seat belts? Yes No
4. What direction were you headed? North South East West
 On (name of street) _____
5. What direction was the other vehicle headed? North South East West
 On (name of street) _____
6. Were you struck from: Behind Front Left Right
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

19. Since this injury occurred, are you symptoms: improving getting worse same

20. Check the symptoms you have noticed since the accident:

- | | | | | |
|--------------------------------------|--|--|--|--|
| <input type="checkbox"/> Headache | <input type="checkbox"/> irritability | <input type="checkbox"/> numbness in toes | <input type="checkbox"/> face flushed | <input type="checkbox"/> feet cold |
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> chest pain | <input type="checkbox"/> shortness of breath | <input type="checkbox"/> buzzing in ears | <input type="checkbox"/> hands cold |
| <input type="checkbox"/> Neck stiff | <input type="checkbox"/> dizziness | <input type="checkbox"/> fatigue | <input type="checkbox"/> loss of balance | <input type="checkbox"/> stomach upset |
| <input type="checkbox"/> Sleeping | <input type="checkbox"/> head seems too heavy | <input type="checkbox"/> depression | <input type="checkbox"/> fainting | <input type="checkbox"/> constipation |
| <input type="checkbox"/> Back pain | <input type="checkbox"/> pin, needles in arms | <input type="checkbox"/> lights bother eyes | <input type="checkbox"/> loss of smell | <input type="checkbox"/> cold sweats |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> pins, needles in legs | <input type="checkbox"/> loss of memory | <input type="checkbox"/> loss of taste | <input type="checkbox"/> fever |
| <input type="checkbox"/> Tension | <input type="checkbox"/> numbness in fingers | <input type="checkbox"/> ears ring | <input type="checkbox"/> 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 questions:

- Last day worked: _____
- Type of employment: _____
- Present salary: _____
- Are you being compensated for time lost from work? Yes No
- If yes, please state type of compensation you are receiving: _____

22. So you notice an activity restriction as a result of this injury? Yes No

If yes, please describe in detail: _____

23. Other pertinent information: _____

Date: _____ Patient's Signature: _____