

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:
- | | | | | |
|--|---|--|--|--|
| <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 Problems | <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"/> Pins & 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 | <input type="checkbox"/> _____ |
- 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