PERSONAL INJURY QUESTIONAIRE

Name: _____ Date of Injury: _____ Phone #: _____

Address: _____ City: _____ State: _____ Zip: _____

Employer's Name: _____ Employer's Address: _____

Your Ins. Co.: _____ Policy #: _____ Agent's Name: _____

Driver/Other Vehicle: _____ Ins. Co.: _____ Policy #: _____

Have you retained an attorney? ☐ Yes ☐ No Name: _____

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: _____ Other vehicle: _____
4. What direction were you headed? ☐ North ☐ East ☐ South ☐ West
   on (name of the street) _____
5. What direction was other vehicle headed? ☐ North ☐ East ☐ South ☐ West
   on (name of the street) _____
6. Were you struck from: ☐ Behind ☐ Front ☐ Left Side ☐ Right Side
7. Were you knocked unconscious? ☐ Yes ☐ No If yes, for how long? _____
8. Were police notified? ☐ Yes ☐ No
9. In your own words, please describe accident: _____

_____

_____

_____

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

_____

_____

_____

11. Please describe how you felt:
    a. DURING the accident: _____
    b. IMMMEDIATELY AFTER the accident: _____
    c. LATER THAT DAY: _____
    d. THE NEXT DAY: _____
12. What are your PRESENT complaints and symptoms? _____

_____

_____

_____

13. Do you have any congenital (from birth) factors which relate to this problem? ☐ Yes ☐ No

If yes, please describe: _____

14. Do you have any previous illnesses which relate to this case? ☐ Yes ☐ No

If yes, please describe: _____

15. Have you ever been involved in an accident before? ☐ Yes ☐ No

If yes, please describe, including dates(s) and type(s) of accidents, as well as injury(ies) received: _____

_____

_____

_____

16. Where were you taken after the accident? _____

17. 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 received? _____

_____

18. Since this injury occurred, are your symptoms: ☐ Improving ☐ Getting Worse ☐ Same

19. CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT:

☐ Headache	☐ Irritability	☐ Numbness in Toes	☐ Feet Cold
☐ Neck Pain	☐ Chest Pain	☐ Shortness of Breath	☐ Hands Cold
☐ Neck Stiff	☐ Dizziness	☐ Fatigue	☐ Stomach Upset
☐ Sleeping Problems	☐ Head Seems Too Heavy	☐ Loss of Balance	☐ Constipation
☐ Back Pain	☐ Pins & Needles in Arms	☐ Loss of Smell	☐ Cold Sweats
☐ Nervousness	☐ Pins & Needles in Legs	☐ Loss of Taste	☐ Fever
☐ Tension	☐ Numbness in Fingers	☐ Diarrhea	☐ _____

Symptoms other than above: _____

20. Have you lost time from work as a result of this accident? ☐ Yes ☐ No

If yes, please complete the questions.

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: _____

21. Do you notice any activity restrictions as a result of this injury? ☐ Yes ☐ No

If yes, please describe in detail: _____

_____

_____

_____

22. Other pertinent information: _____

_____

_____

Patient's Signature: _____ Date: _____