PERSONAL INJURY QUESTIONNAIRE

Name _____ Phone ( ) _____

Address _____ City _____ State _____ Zip _____

Age _____ Birthdate _____ Sex _____ S/S # _____

Employers Name _____ Employers Address _____

Your Auto Insurance Co. _____ Policy # _____

Name on Policy (if other than self) _____

Responsible Parties Name (person who caused accident) _____

Responsible Parties Auto Insurance Co. _____ Policy # _____

ATTORNEY

Name _____ Phone ( ) _____

Address _____ City _____ State _____ Zip _____

Were there any witnesses? ( ) Yes ( ) No Names _____

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) _____ In (City) _____

5. What direction was the other vehicle headed in? ( ) North ( ) East ( ) South ( ) West

on (name of street) _____

. Were you struck from: ( ) Behind ( ) Front ( ) Left Side ( ) Right Side

Approximate speed of your car _____ mph Other car _____ mph

Were you knocked unconscious? ( ) Yes ( ) No If yes, for how long? _____

Were the police notified? ( ) Yes ( ) No If yes, was a police report done? ( ) Yes ( ) No

. In your own words, please describe the accident: _____

_____

_____

_____

Did you have any physical complaints BEFORE THE ACCIDENT? ( ) Yes ( ) No If yes please describe in detail:

_____

_____

_____

lease describe how you felt physically (ie. Neck pain, dizziness, leg pain etc.)

During the accident: _____

Immediately after the accident: _____

Later that 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:

_____

_____

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 doctors name and address:

_____

What type of treatment did you receive? _____

_____

19. Since the injury occurred, are your symptoms: ( ) Improving ( ) Getting Worse ( ) Same

20. CHECK SYPMTOMS 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 Problems	[ ] Head Seems to 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. 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: _____

_____

_____

_____