PERSONAL INJURY QUESTIONNAIRE

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 street)____

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

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. IMMEDIATELY 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 illness 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 date(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 receive? ____

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

19. CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT:

☐Headache	☐Irritability	☐ Numb Toes	☐Face Flushed	☐Feet Cold
☐NeckPain	☐Chest Pain	☐Short/Breath	☐Buzzing in Ears	☐Hands Cold
☐Neck Stiff	☐Dizzinesess	☐Fatigue	☐Loss of Balance	☐Stomach Upset
☐Sleep problem	☐Head to Heavy	☐Depression	☐Fainting	☐Constipation
☐Back Pain	☐Pain/ Arms	☐Light hurts eyes	☐Loss of Smell	☐Cold Sweats
☐Nervousness	☐Pain/ Legs	☐Loss of memory	☐Loss of Taste	☐Fever
☐ Tension	☐Numb Fingers	☐Ears Ring	☐Diarrhea	☐_________

Symptoms Other Than Above ____

20. 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: ____

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: ____

____

____

____________________________ ____

Date Patient's Signature