

PERSONAL INJURY QUESTIONNAIRE

INFORMATION ABOUT YOU

Name _____ Phone _____

Address _____ City _____ State _____ Zip _____

Age _____ Birthdate _____ Sex () M () F SS# _____

Employer's Name _____ Employer's Address _____

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

Responsible Party's Name _____

Address _____ City _____ State _____ Zip _____

Policy Holder's Name _____

INFORMATION ABOUT YOUR ATTORNEY

Name _____ Phone _____ Fax _____

Address _____ City _____ State _____ Zip _____

Were there any Witnesses? () Yes () No. Names _____

INFORMATION ABOUT YOUR 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? () Yes () No

4. What direction were you headed? () North () East () South () West

5. What direction was the 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 the accident: _____

11. Did you have any physical complaints BEFORE THE ACCIDENT? () Yes () No

If yes, describe: _____

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?

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 injuries received:

17. Where were you taken after the accident? _____

18. Have you been treated by another doctor since the accident? () Yes () No

If yes, names: _____

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

20. CHECK SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT.

HEADACHE	IRRITABILITY	NUMBNESS-TOES	FACE FLUSHED	FEET COLD
NECK PAIN	CHEST PAIN	SHORNESS-BREATH	BUZZING IN EARS	HANDS COLD
NECK STIFF	DIZZINESS	FTIGUE	LOSS OF BALANCE	STOMACH UPSET
SLEEPING PROBLEM	HEAD IS HEAVY	DEPRESSION	FAINING	CONSTIPATION
BACK PAIN	PIN/NEEDLES ARMS	LIGHT SENSITIVE EYES	LOSS OF SMELL	COLD SWEATS
NERVOUSNESS	PIN/NEEDLES LEGS	LOSS OF MEMORY	LOSS OF TASTE	FEVER
TENSION	NUMBNESS-FINGERS	EARS RING	DIARRHEA	_____

Symptoms other than above _____

21. Have you lost time from work as a result of this accident? () Yes () No

a. Last day worked: _____

b. Type of employment: _____

c. Present Salary: _____

d. Are you being compensated for time lost from work? () Yes () No

22. Do you notice any activity restrictions as a result of this injury () Yes () No

If yes, please describe: _____

23. Other pertinent information: _____

DATE

PATIENT'S SIGNATURE

