

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 problem? () 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 Ringing	<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