

PERSONAL INJURY QUESTIONNAIRE

Name _____ Phone () _____
Address _____ City _____ State _____ Zip _____
Age ____ Birthdate _____ Sex ____ SSN _____
Employer's Name _____ Employer's Address _____
Your Auto Ins. Co _____ Policy # _____
Name on Policy (if different) _____ Agent _____
Claim Number _____ Phone () _____

Liabile Party Name _____
Address _____ City _____ State _____ Zip _____
Liabile Party Auto Ins. Co _____ Policy # _____
Claim Number _____ Phone () _____
Name on Policy (if different) _____ Address _____

Attorney _____ Phone () _____
Address _____ City _____ State _____ Zip _____
Were there any witnesses? () Yes () No Name(s) _____

Date of Accident _____ Time of Day _____
Were you: () Driver () Passenger () Front Seat () Back Seat
Number of people in your vehicle _____ Were you wearing seat belts ____
What direction were you headed?() North () South () East () West
Name of street or intersection _____
What direction was other vehicle headed?() North() South() East() West
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 police notified? () Yes () No
In your own words, please describe accident: _____

Did you have any physical complaints BEFORE THIS ACCIDENT?() Yes() No
If yes, please describe _____

Please describe how you felt:
A) During the accident _____
B) Immediately after _____
C) Later that day _____
D) The next day _____

What are your ACCIDENT RELATED complaints and symptoms? _____

Do you have any congenital factors which relate to this problem () Y () N
If yes, please describe _____

Do you have any previous illnesses which relate to this case? () Y () N

If yes, please describe _____

Have you ever been involved in an accident before? () Y () N

If yes, please describe including date(s) and type(s) of accidents, as well as injuries received: _____

Where you taken after this accident _____

Have you been treated by another doctor since the accident () Y () N

If yes, please list the doctor's name, phone, and address _____

What type of treatment did you receive _____

Since this injury are you symptoms: () Improving () Getting worse () Same

Check symptoms you have noticed SINCE THIS ACCIDENT:

() Headache () Irritability () Numbness in Toes () Face Flushed () Fever

() Neck Pain () Chest Pain () Shortness of Breath () Buzzing in Ears

() Feet Cold () Hands Cold () Neck Stiff () Dizziness () Fatigue

() Loss of Balance () Upset Stomach () Sleeping Problems () Fainting

() Depression () Head Seems too Heavy () Constipation () Back Pain

() Pins and Needles in Arms () Pins and Needles in Legs () Nervousness

() Lights Bother Eyes () Loss of Smell () Cold Sweats () Loss of Memory

() Loss of Taste () Tension () Numbness in Fingers () Ears Ring

() Diarrhea () Other _____

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

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

If yes, please describe _____

Other pertinent information _____

Date: _____ Patient Signature: _____