

## 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 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 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 Ring           | <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