

Personal Injury Questionnaire

Name _____ Phone Number _____

Address _____ City _____ State _____ Zip _____

Age _____ Birthdate _____ Sex _____ S/S# _____

Email Address _____

Employer's Name _____ Employer's Address _____

Your Insurance Company _____ Policy# _____ Agent's name _____

Name on your policy (if other than self) _____ Policy# _____

Responsible Party's Name _____

Address _____ City _____ State _____ Zip _____

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Policy Holder's Name _____ Policy # _____

ATTORNEY

Name _____ Phone Number _____

Address _____ City _____ State _____ Zip _____

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Were there any witnesses? ()Yes ()No Name(s) _____

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NATURE OF ACCIDENT

Date Of accident _____ Time of Day _____

Were you: ()Driver ()Passenger ()Front Seat ()Back Seat

Number of people in your vehicle? _____ Were you wearing a seatbelt? _____

What direction were you headed? ()North ()South ()East ()West on (name of street)

Were you struck from: ()Front ()Back ()Left ()Right

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 the accident: _____

Did you have any physical complaints BEFORE THE ACCIDENT? ()Yes ()No If yes, please describe in detail: _____

Please describe how you felt:

- a. DURING the accident _____
- b. IMMEDIATELY AFTER the accident: _____
- c. LATER THAT DAY: _____
- d. THE NEXT DAY: _____

What are your present complaints and symptoms? _____

Do you have any congenital (from birth) factors which relate to this problem? ()Yes ()No If yes, please describe _____

Do you have any previous illnesses which relate to this case? ()Yes ()No If yes, please describe: _____

Have you ever been involved in an accident before? ()Yes ()No If yes, please describe, including dates and types of injuries received _____

Where were you taken after this accident? _____

Have you been treated by another Doctor since this accident? ()Yes ()No If yes, please list doctor's name and address: _____

What type of treatment did you receive? _____

Since this injury occurred, are your symptoms: ()Improving ()Staying the same ()Getting worse

CIRCLE THE SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT

Headache	Irritability	Numbness in Toes	Face Flushed	Feet Cold
Neck Pain	Chest Pain	Shortness of Breath	Buzzing in Ears	Hands Cold
Neck Stiff	Dizziness	Fatigue	Loss of Balance	Stomach Upset
Sleeping Problems	Head seems too heavy	Depression	Fainting	Constipation
Back Pain	Pins and Needles in Arms	Lights Bother Eyes	Loss of Smell	Cold Sweats
Nervousness	Pins and Needles in Legs	Loss of Memory	Loss of Taste	Fever
Tension	Numbness in Fingers	Ears Ring	Diarrhea	Other

Symptoms other than above: _____

Have you lost time from work as a result of this accident? ()Yes ()No If yes, please complete the following:

- a. Last day worked: _____
- b. Type of employment: _____
- c. Present Salary: _____
- d. Are you being compensated for time lost from work? _____

Do you notice any activity restrictions as a result of this injury? ()Yes ()No If yes, please describe, in detail: _____

Other pertinent information: _____

Date: _____ Signature: _____