

## 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       | <input type="checkbox"/> Buzzing in Ears | <input type="checkbox"/> Hands Cold    |
| <input type="checkbox"/> Neck Stiff        | <input type="checkbox"/> Dizziness              | Breath                                      | <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"/> Fatigue            | <input type="checkbox"/> Fainting        | <input type="checkbox"/> Constipation  |
| <input type="checkbox"/> Back Pain         | <input type="checkbox"/> Pins & Needles in Arms | <input type="checkbox"/> Depression         | <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"/> Lights Bother Eyes | <input type="checkbox"/> Loss of Taste   | <input type="checkbox"/> Fever         |
| <input type="checkbox"/> Tension           | <input type="checkbox"/> Numbness in Fingers    | <input type="checkbox"/> Loss of Memory     | <input type="checkbox"/> Diarrhea        | 0 _____                                |
|  |   | <input type="checkbox"/> Ears Ring          |  |  |

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