

Personal Injury Questionnaire

Name _____ Phone () _____
Address _____ City _____ State _____ Zip _____
Age _____ Birth date _____ Sex _____ Work Number () _____
Employer's Name _____ Address _____

CLAIM INFORMATION (of the owner of the OTHER vehicle)

Insurance Company _____ Adjuster Name _____
Adjuster Phone () _____ Claim # _____
Name on Policy _____ Policy # _____
Billing Address _____ City _____ State _____ Zip _____

ATTORNEY or ADVOCATE INFORMATION

Name _____ Phone () _____
Address _____ City _____ State _____ Zip _____
Were there witnesses? () No () Yes 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 () South () East () West on (name of street) _____

5. What direction was the other vehicle headed? () North () South () East () West on (name of street) _____

6. From which direction were you struck? () Behind () Front () Left side () Right side
7. Approximate speed of your car was _____ mph; other car _____ mph.
8. Were you knocked unconscious? () No () Yes (If yes, for how long): _____
9. Were police notified? () No () Yes (If yes, was a report taken): _____
10. In your own words, please describe the accident. _____

11. Did you have any physical complaints BEFORE THE ACCIDENT? () No () Yes (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 factors which relate to the problem? () No () Yes (If yes, please describe): _____

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

16. Where were you taken after this accident? _____

17. Have you been treated by another doctor since this accident? () No () Yes (If yes, list Dr.'s name & address): _____

What type of treatment did you receive? _____

18. Since this injury occurred, are your symptoms: () Improving () Getting Worse () Staying the Same

19. CHECK 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 | () Ears Ring |
| () Sleep Problems | () Head feels Heavy | () Depression | () Fainting | () Constipation |
| () Back Pain | () Pins & Needles in Arms | () Lights Bother Eyes | () Loss of Smell | () Cold Sweats |
| () Nervousness | () Pins & Needles in Legs | () Loss of Memory | () Loss of Taste | () Fever |
| () Tension | () Numbness in Fingers | () Upset Stomach | () Diarrhea | () _____ |

Symptoms other than above _____

20. Have you lost time from work as a result of this accident? () No () Yes (If yes, complete A-D)

a. Last Day Worked: _____

b. Type of Employment: _____

c. Present Salary: _____

d. Are you being compensated for time off of work? () No () Yes (If yes, please state type of compensation): _____

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

22. Have you ever been involved in an accident before: () No () Yes (If yes, please describe, including date(s) and type(s) of accidents, as well as injury(ies) received): _____

23. Other pertinent information: _____

DATE

PATIENT'S SIGNATURE