Personal Injury Questionnaire

Name ______________________________ Social Security Number ____________________
Date of Birth ___________ Home Number ________________ Mobile ___________________
Address _______________________ City __________________State _______ Zip __________
Employer's Name _______________________ Employer's Address _____________________
Your Insurance Company ________________________ Policy number ___________________
Agent's Name ______________________ Agent's Phone Number _____________________
Claim Number _____________ Claim Adjuster's Name_______________________________
Claim Adjuster's Phone Number ____
Address to send claims____
Have you retained an attorney? ( ) Yes ( ) No Name ______________________________
Phone number____
Attorney's address____

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? ____________________ Other vehicle? ___________
4. Type of vehicle you were driving? _________year__________make____________model
5. Nearest intersection to the accident ____
6. What Direction were you headed? ( ) North ( ) East ( ) South ( ) West
   On (name of street) ____
7. What direction was the other vehicle headed? ( ) North ( ) East ( ) South ( ) West
8. Were you struck from: ( ) Behind ( ) Front ( ) Left side ( ) Right side
7. Were you rendered unconscious? ( ) Yes ( ) No If yes, for how long? ______________
9. Were the police notified? ( ) Yes ( ) No! If so, were any citations issued and to whom?
   ____
10. In your own words, please describe the 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?
( ) 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. Have you ever been involved in an accident before: ( ) No ( ) Yes If yes, please describe, including date(s) and Type(s) of accident(s), doctor(s) you treated with, as well as injury(s) 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 the 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 THE ACCIDENT:

Headache	Irritability	Numbness in Toes	Face Flushed	Cold Feet
Neck Pain	Chest Pain	Shortness of Breath	Buzzing in Ears	Cold Hands
Neck Stiffness	Dizziness	Fatigue	Loss of Balance	Upset Stomach
Sleeping problems	Head seems heavy	Depression	Fainting	Constipation
Back problems	Pins & needles in arms	Light bother eyes	Loss of smell	Cold Sweats
Nervousness	Pins & needles in legs	Loss of memory	Loss of Taste	Fever
Tension	Numbness in Fingers	Ringing in Ears	Diarrhea	____________

Symptoms Other Than Above ____________ What makes symptoms better or worse?

21. Have you lost time from work as a result of this accident? ( ) Yes ( ) No If yes, please complete the following questions:
a. Last day worked:
b. Type of Employment:
c. 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:

24. Make/Model of your vehicle
Make/Model of their vehicle
Did you have your foot on the gas or brake pedal?

Date

Patient's Signature