

**PERSONAL INJURY QUESTIONNAIRE**

Name \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Age \_\_\_\_\_ Birthdate \_\_\_\_\_ Sex \_\_\_\_\_ SS# \_\_\_\_\_

Employer's Name \_\_\_\_\_ Employer Address \_\_\_\_\_

Your Insurance Co. \_\_\_\_\_ Policy # \_\_\_\_\_

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 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? ( ) 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 dates(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 the Accident:**

- |  |   |  |                                     |
|--|---|--|-------------------------------------|
| <input type="checkbox"/> Headaches         | <input type="checkbox"/> Irritability           | <input type="checkbox"/> Numbness in Toes    | <input type="checkbox"/> Feet Cold  |
| <input type="checkbox"/> Neck pain         | <input type="checkbox"/> Chest Pain             | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Hands Cold |
| <input type="checkbox"/> Neck stiff        | <input type="checkbox"/> Dizziness              | <input type="checkbox"/> Buzzing in Ears     | <input type="checkbox"/> Cold Sweat |
| <input type="checkbox"/> Sleeping problems | <input type="checkbox"/> Head Seems too heavy   | <input type="checkbox"/> Depression          | <input type="checkbox"/> Fever      |
| <input type="checkbox"/> Back pain         | <input type="checkbox"/> Pins & Needles in Arms | <input type="checkbox"/> Lights Bother Eyes  | <input type="checkbox"/> Fainting   |
| <input type="checkbox"/> Nervousness       | <input type="checkbox"/> Pins & Needles in Legs | <input type="checkbox"/> Loss of Memory      | <input type="checkbox"/> Diarrhea   |
| <input type="checkbox"/> Tension           | <input type="checkbox"/> Numbness in Fingers    | <input type="checkbox"/> Ears Ringing        | <input type="checkbox"/> Face Flush |
| <input type="checkbox"/> Loss of Balance   | <input type="checkbox"/> Loss of Smell          | <input type="checkbox"/> Loss of Taste       | <input type="checkbox"/> Fatigue    |
| <input type="checkbox"/> Constipation      | <input type="checkbox"/> Stomach Upset          |  |                                     |

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

Patients Signature