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 physcial 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 accidednts, 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**:

☐	Headaches	☐	Irritability	☐	Numbness in Toes	☐	Feet Cold
☐	Neck pain	☐	Chest Pain	☐	Shortness of Breath	☐	Hands Cold
☐	Neck stiff	☐	Dizziness	☐	Buzzing in Ears	☐	Cold Sweat
☐	Sleeping problems	☐	Head Seems too heavy	☐	Depression	☐	Fever
☐	Back pain	☐	Pins & Needles in Arms	☐	Lights Bother Eyes	☐	Fainting
☐	Nervousness	☐	Pins & Needles in Legs	☐	Loss of Memory	☐	Diarrhea
☐	Tension	☐	Numbness in Fingers	☐	Ears Ringing	☐	Face Flush
☐	Loss of Balance	☐	Loss of Smell	☐	Loss of Taste	☐	Fatique
☐	Constipation	☐	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 receiveing: _____

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

23. Other pertinent information: _____
_____

_____
Date Patients Signature