PERSONAL INJURY QUESTIONNAIRE

Name_____Phone ( )_____

Address _____City_____State_____Zip_____

Age_____Birthdate_____ Sex M F S/S#_____

Employer's Name_____Employer's Address_____

Your Auto Ins. Co._____ Claim #_____

Adjustor's Name _____ Phone ( )_____

Name on Policy (If other than self)_____ Policy #_____

RESPONSIBLE PARTY

Name_____Phone ( )_____

Address _____City_____State_____Zip_____

Auto Ins. Co. _____ Claim #_____

Adjustor's Name_____ Phone ( )_____

Name on Policy (If other than responsible party)_____

ATTORNEY

Name_____Phone ( )_____

Address _____City_____State_____Zip_____

Were there any witnesses? ( ) Yes ( ) No

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? ( ) Yes ( ) No
4. What direction were you headed? ( ) North ( ) East ( ) South ( ) West
5. What direction was the other vehicle headed? ( ) North ( ) East ( ) South ( ) West
6. Were you struck from: ( ) Behind ( ) Front ( ) Driver's Side ( ) Passenger side
7. Approximate speed of; Your car: _____mph The 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 in detail: _____

_____

15. Do you have any previous illnesses which relate to this case? ( ) Yes ( ) No

If yes, please describe in detail: _____

_____

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 the doctor's name and address: _____

_____

What type of treatment did you receive? _____

_____

19. Since this injury occurred, are your symptoms: ( ) Improving ( ) Getting better ( ) Same

20. 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 Stiffness	□Dizziness	□Fatigue	□Loss of Balance	□Stomach Upset
□Sleeping Problems	□Head Seems Too 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

Symptoms Other than Above: _____

21. Have you lost time from work as a result of this accident? ( ) Yes ( ) No

If yes, please complete the following:

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: _____