

# PERSONAL INJURY QUESTIONNAIRE

## INFORMATION ABOUT YOU

Name \_\_\_\_\_ Phone \_\_\_\_\_

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

Age \_\_\_\_\_ D.O.B. \_\_\_\_\_ Sex ( ) M ( ) F Status M S W D S/S # \_\_\_\_\_

Occupation Name \_\_\_\_\_ Address \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Occupation \_\_\_\_\_

Your Ins. Co. \_\_\_\_\_ Agent's Name \_\_\_\_\_ Phone # \_\_\_\_\_

Name on Policy(if other than self) \_\_\_\_\_ Claim# \_\_\_\_\_

Responsible Party's Name \_\_\_\_\_

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

Policy Holder's Name \_\_\_\_\_

## INFORMATION ABOUT YOUR ATTORNEY

Name \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

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

Were there any witnesses? ( ) Yes ( ) No Name \_\_\_\_\_

## INFORMATION ABOUT YOUR 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

on (name of street) \_\_\_\_\_

6. Were you struck from: ( ) Behind ( ) Front ( ) Left side ( ) Right Side

7. Approximate speed of yur 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, describe: \_\_\_\_\_

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?

\_\_\_\_\_  
\_\_\_\_\_

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 date(s) and type(s) of accidents as well as injuries received: \_\_\_\_\_

\_\_\_\_\_

17. Where were you taken after your current accident? \_\_\_\_\_

18. Have you been treated by another doctor since the accident? ( ) Yes ( ) No

If yes, names: \_\_\_\_\_

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

20. CHECK SYMPTOMS YOU HAVE NOTICE SINCE ACCIDENT:

- |                      |                       |                          |                     |                   |
|----------------------|-----------------------|--------------------------|---------------------|-------------------|
| ( ) HEADACHE         | ( ) IRRITABILITY      | ( ) NUMBNESS-TOES        | ( ) FACE FLUSHED    | ( ) FEET COLD     |
| ( ) NECK PAIN        | ( ) CHEST PAIN        | ( ) SHORTNESS-BREATH     | ( ) BUZZING IN EARS | ( ) HANDS COLD    |
| ( ) NECK STIFF       | ( ) DIZZINESS         | ( ) FATIGUE              | ( ) LOSS OF BALANCE | ( ) STOMACH UPSET |
| ( ) SLEEPING PROBLEM | ( ) HEAD IS HEAVY     | ( ) DEPRESSION           | ( ) FAINTING        | ( ) CONSTIPATION  |
| ( ) BACK PAIN        | ( ) PINS/NEEDLES ARMS | ( ) LIGHT SENSITIVE EYES | ( ) LOSS OF SMELL   | ( ) COLD SWEAT    |
| ( ) NERVOUSNESS      | ( ) PINS/NEEDLES LEGS | ( ) LOSS OF MEMORY       | ( ) LOSS OF TASTE   | ( ) FEVER         |
| ( ) TENSION          | ( ) NUMBNESS-FINGER   | ( ) EARS RING            | ( ) DIARRHEA        | ( ) _____         |

Symptoms other than above \_\_\_\_\_

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

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, 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: \_\_\_\_\_

\_\_\_\_\_

Other pertinent information: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_