PERSONAL INJURY QUESTIONNAIRE

Name: ____ Phone ( ) ______________

Address: ______________________________ City____________ State______ Zip __________

Age________ Birthdate_________________ Sex__________ S/S#______________________

Employer's Name_________________________________ Address_______________________

Your Ins. Co ____________________________ Policy#_________________ Agents Name________

Name On Policy (if other then self) ______________________________ Policy #_______________

Responsible Party's Name ____

Address________________________________ City ___________________State______Zip______

Policy Holder's Name ________________________________Policy#________________________

ATTORNEY

Name____ Phone( ) __________________

Address_____________________________________City________________ State_____Zip______

Were there 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 seatbelts? ____________
4. What directions were you headed? ( ) North ( ) South ( ) East ( ) West

   On (name of street) ____
5. What direction was the other vehicle headed( ) North ( ) South ( ) East ( ) 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, 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:

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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 date(s) and type(s) of accidents, as well as injury(ies) received.

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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 the injury occurred, are your symptoms ( ) improving ( ) getting worse ( ) same
20. Check All Symptoms you have noticed since accident:

Headache	Irritability	Numbness in Toes	Face Flushed	Feet Cold
Neck Pain	Chest Pain	Shortness of Breath	Buzzing in Ears	Hands Cold
Neck Stiff	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	Pin/Needles in legs	Loss of Memory	Loss of Taste	Fever
Tension	Numbness in Fingers	Ears Ring	Diarrhea	Other: ____________

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:

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____

____

Patient's Signature: ____

Patient's Name:____

Date: ______________________________