PERSONAL INJURY QUESTIONNAIRE

Name _____ Phone _____

Address _____ City _____ State _____ Zip _____

Age _____ Birthdate _____ Sex [ ]Male [ ]Female

Employer's Name _____ Employer's Address _____

Your Insurance Company _____ Adjuster's Name _____

Claim # _____

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

Responsible Party's Name _____

Other Driver's Insurance Company _____ Policy # _____

Claim # _____

Attorney Name _____ Phone _____

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? [ ]Yes [ ]No

4. What direction were you headed? [ ]North [ ]East [ ]South [ ]West
   on (name of street) _____

5. What direction was the other vehicle headed? [ ]North [ ]East [ ]South [ ]West More than one car _____
   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

9. Were the 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:

- DURING THE ACCIDENT: _____
- IMMEDIATELY AFTER THE ACCIDENT: _____
- LATER THAT DAY: _____
- 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 illness which relates 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: _____

_____

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 and type of treatment: _____

19. Since the injury occurred are your symptoms: [ ]Improving [ ]Getting Worse [ ]Same

20. CHECK THE 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 Stiff	[ ]Dizziness	[ ]Fatigue	[ ]Loss of balance	[ ]Stomach upset
[ ]Sleeping Problems	[ ]Head seems too heavy	[ ]Depression	[ ]Fainting	[ ]Constipation
[ ]Back Pain	[ ]Pins and needles in arms	[ ]Light bothers eyes	[ ]Loss of smell	[ ]Cold sweats
[ ]Nervousness	[ ]Pins and needles in legs	[ ]Loss of memory	[ ]Loss of taste	[ ]Fever
[ ]Tension	[ ]Numbness in fingers	[ ]Ears ringing	[ ]Diarrhea	[ ]_____

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:

- Type of employment: _____
- Present salary: _____
- Are you being compensated for time lost from work? [ ]Yes [ ]No If yes, please describe in detail: _____

_____

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: _____

_____

Patient Signature: _____ Date: _____