PERSONAL INJURY QUESTIONNAIRE

Home Phone ( ) _____

Name _____ Work Phone ( ) _____

Address _____ City _____ State _____ Zip _____

Age _____ Birthdate _____ Marital Status _____ Sex _____ S/S # _____

Employer's Name _____ Employer's Address _____

Your Ins. Co. _____ Policy # _____ Adjuster's Name _____

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

Ins. Co. Address _____ City _____ State _____ Zip _____

Ins. Co. Phone # _____ Ext. _____

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. What position was your head at time of impact? Looking straight ahead_____ Turned Left_____ Turned Right_____
10. Were police notified? ☐ Yes ☐ No
11. In your own words, please describe accident: _____
12. Did you have any physical complaints BEFORE THE ACCIDENT? ☐ Yes ☐ No If yes, please describe in detail:
13. Please describe how you felt:
    a. DURING the accident: _____
    b. IMMEDIATELY AFTER the accident: _____
    c. LATER THAT DAY: _____
    d. THE NEXT DAY: _____

14. Where were you taken after the CURRENT accident? _____

15. 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? (ex: MRI, X-Ray, Meds) _____

_____

16. Since this injury occurred, are your symptoms: ☐ Improving ☐ Getting Worse ☐ Same

17. CHECK 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	☐ Pins & Needles in Legs	☐ Loss of Memory	☐ Loss of Taste	☐ Fever
☐ Tension	☐ Numbness in Fingers	☐ Ears Ring	☐ Diarrhea	☐ _____

Symptoms Other Than Above _____

18. What are your PRESENT complaints and symptoms? _____

_____

_____

19. 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. _____

_____

_____

20. Do you have any previous illnesses which relate to this case? ☐ Yes ☐ No If yes, please describe:

21. Do you have any congenital (from birth) factors which relate to this problem? ☐ Yes ☐ No If yes, please describe:

_____

_____

22. 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: _____

23. Do you notice any activity restrictions as a result of this injury? ☐ Yes ☐ No If yes, please describe, in detail:

_____

_____

_____

24. Other pertinent information: _____

25. Please list all medications you are taking? _____

26. List any types of surgeries and dates? _____

27. Liquor consumed on a weekly basis? _____

28. Do you smoke? _____ If yes, how much per day? _____

29. Any significant family medical history _____

_____ DATE

_____ PATIENT'S SIGNATURE