PERSONAL INJURY QUESTIONNAIRE

Name _____ Phone ( ) _____
Address _____ City _____ State _____ Zip _____
Age _____ Birthdate _____ Sex _____ S/S # _____
Employer's Name _____ Employer's Address _____
Your Ins. Co. _____ Policy # _____ Agent's Name _____
Name on Policy (If other than self) _____ Policy # _____
Responsible Party's Name _____
Address _____ City _____ State _____ Zip _____
Policy Holder's Name _____ Policy # _____

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. Your vehicle type: ( ) coupe ( ) sedan ( ) van ( ) pick-up truck ( ) sport-utility vehicle ( ) truck ( ) station wagon ( ) other _____
3. Your vehicle size: ( ) compact ( ) subcompact ( ) light ( ) mid-size ( ) full-size ( ) mini
4. Amount damage to vehicle: ( ) minimal ( ) moderate ( ) complete ( ) extensive
5. Other vehicle type: ( ) coupe ( ) sedan ( ) van ( ) pick-up truck ( ) sport-utility vehicle ( ) truck ( ) station wagon ( ) trailer ( ) other _____
6. Other vehicle size: ( ) compact ( ) subcompact ( ) light ( ) mid-size ( ) full-size ( ) mini
7. Damage to other vehicle: ( ) minimal ( ) moderate ( ) complete ( ) extensive
8. Weather condition: ( ) clear ( ) sunny ( ) cloudy ( ) drizzling ( ) foggy ( ) rainy ( ) stormy ( ) snowing
9. Visibility: ( ) poor ( ) fair ( ) good
10. Road condition: (i.e.: dry, wet, iced over....) _____
11. Were you: ( ) Driver ( ) Front right passenger ( ) Front middle passenger ( ) Back right passenger ( ) Back middle passenger ( ) Back left passenger
12. Number of people in your vehicle? _____ Were you wearing seat belts? _____
13. What direction were you headed? ( ) North ( ) East ( ) South ( ) West on (name of street) _____
14. What direction was other vehicle headed? ( ) North ( ) East ( ) South ( ) West on (name of street) _____
15. Were you struck from: ( ) Behind ( ) Front ( ) Left side ( ) Right side

16. Approximate speed of your car: _____ mph Other vehicle _____ mph
17. Body position of impact: ( ) leaning forward ( ) slouched down in the seat ( ) straight ( ) turned left ( ) turned right ( ) other _____
18. Direction body of thrown: ( ) backward then forward ( ) forward then backward ( ) to the left ( ) to the right ( ) outside the vehicle ( ) under the vehicle ( ) above the vehicle
19. Head position of impact: ( ) straight ( ) tilted forward ( ) turned left ( ) turned right
20. Direction head thrown: ( ) backward then forward ( ) forward then backward ( ) side to side
21. Position of head rest: ( ) high position ( ) middle position ( ) low position ( ) not installed
22. Did the airbag deploy: ( ) Yes ( ) No
23. Were you knocked unconscious? ( ) Yes ( ) No If yes, for how long? _____
24. Did you brace for impact: ( ) Yes ( ) No
25. Were police notified? ( )Yes ( ) No
26. In your own words, please describe accident: _____

_____

_____

_____

27. Did you have any physical complaints BEFORE THE ACCIDENT? ( )Yes ( ) No
If yes, please describe in detail: _____

_____

_____

_____

28. Please describe how you felt:
    a. DURING the accident: _____
    b. IMMEDIATELY AFTER the accident: _____
    c. LATER THAT DAY: _____
    d. THE NEXT DAY: _____
29. What are your PRESENT complaints and symptoms?

_____

_____

_____

30. Do you have any congenital (from birth) factors which relate to this problem? ( )Yes ( ) No
If yes, please describe: _____
31. Do you have any previous illnesses which relate to this case? ( ) Yes ( ) No
If yes, please describe: _____
32. 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.

_____

_____

_____

33. Where were you taken after the accident? _____

34. Have you been treated by another doctor since the accident? ( ) Yes ( ) No
If yes, please list doctor's name and address: Doctor's name: _____
Address: _____

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

36. CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT:

( ) Headache	( ) Irritability	( ) Numbness in toes	( ) Face flushed	( ) Feel 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 both eyes	( ) Loss of smell	( ) Cold sweats
( ) Nervousness	( ) Pins & needles in legs	( ) Lost of memory	( ) Loss of taste	( ) Fever
( ) Tension	( ) Numbness in fingers	( ) Ears ring	( ) Diarrhea	( )

Symptoms Other Than Above: _____

37. 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. Are you being compensated for time lost from work? ( ) Yes ( ) No
If yes, please state type of compensation you are receiving: _____

38. Do you notice any activity restrictions as a result of this Injury? ( ) Yes ( ) No
If yes, please describe, in detail: _____
_____
_____

39. Other pertinent information: _____
_____
_____
_____
_____

_____ _____
Date Patient's Signature