PERSONAL INJURY QUESTIONNAIRE

(Please use additional paper and attach should you need more space)

First Name:_____ Last Name: _____ Phone ( ) _____ - _____

Address: _____ City: _____

State: _____ Zip: _____ Email: _____

Age:_____ Birthday: _____/_____/_____ Sex: ( ) F ( ) M SS#: _____-_____-_____

Employer's Name: _____

Employer's Address: _____

Your Insurance 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 INFORMATION

Name: _____ Phone: (_____) _____ -_____

Address: _____ City:_____ State: _____ Zip:_____

Were there any witnesses? ( ) Yes ( ) No If so, list e(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? ( ) Yes ( ) No
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. Were police notified? ( ) Yes ( ) No
10. In your own words, please describe 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:
    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/injuries 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 doctor's name and address:_____

_____

What type of treatment did you receive? _____

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

20. **CHECK 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	☐ Pins & Needles in Legs	☐ Constipation	☐ Fainting	☐ Loss of Smell
☐ Ears Ring	☐ Head Seems Too Heavy	☐ Depression	☐ Fever	☐ Cold Sweats
☐ Diarrhea	☐ Tension	☐ Lights Bother Eyes	☐ Nervousness	☐ Loss of Taste
☐ Back Pain	☐ Loss of Memory	☐ Numbness in Fingers	☐ Loss of Memory	☐ Pins & Needles in Arms

Symptoms Other Than Listed Above:_____

21. Have you lost time from work as a result of this accident? ( ) Yes ( ) No If yes, please complete the following:

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: _____

_____ _____

DATE **PATIENT'S SIGNATURE**