Personal Injury Questionnaire

Name__________________________ Date of Birth___________ Phone_______________
Address_________________________ City__________________ State____ Zip_______
Employer Name__________________ _ Employer Address____________________________
Your Ins.Co.______________________ Policy#_____________Agent Name_____________
Other Driver_____________________ Ins.Co._________________ Policy#______________
Your attorney name: _______________ Phone__________________
Address_______________________City_____________________State____Zip________
Were there any witnesses?__________Name(s)___________________________________

Nature of Accident:

1. Date of Accident___________Time of day______________Weather________________
2. Were you: Driver□ Passenger □ Front Seat □ Back Seat □
3 Seat belt: None □ Wearing □ Not wearing □
4. Shoulder harness: None □ Wearing □ Not wearing □
5. Head Rest: None □ Integral □ Adjusted in __________ position.
6. Head Position: Ahead □ Right □ Left □ Brakes on: Yes □ No □
7. Number of people in your vehicle?______________Other vehicle?__________________
8. Were others hurt: Yes □ No □
9. What direction were you headed? North □ South □ East □ West □ on (name of street)____
10. What direction was other vehicle headed? North □ South □ East □ West □ on (name of street)____
11. Were you struck from: Behind □ Front □ Left Side □ Right Side □
12. How fast were you traveling?_____________Other vehicles speed?_________________
13. Were you knocked unconscious?__________ If yes, for how long?__________________
14. Did you have a hat or glasses on: Yes □ No □ Did they come off: Yes □ No □
15. Were the police notified: Yes □ No □ Was a police report made: Yes □ No □
16. Model/Make/Year of your vehicle____
    Model/Make/Year of other vehicle____
17. In your own words, please describe the accident:
____
____
____
18. Where were you taken after the accident?_____________________________________
19. Have you been treated by another doctor since the accident?________If yes, please list the doctors name and address:____
____
20. What type of treatment did you receive?_____________________________________
____

Nature of your complaints

21. Since this injury occurred are your symptoms:
    Improving □ Getting worse □ Same □

22. Check the symptoms you have noticed since the accident:
Headache___ Irritability___ Numbness in toes___ Face Flushed___ Cold Feet ___
Neck Pain___ Chest Pain___ Shortness of breath___ Buzzing in ears___ Cold Hands___
Stiff Neck___ Dizziness___ Fatigue___ Loss of Balance___ Upset Stomach___
Sleeping Problems___ Head seems too Heavy___ Depression____ Fainting___
Constipation___ Back Pain___ Pins & Needles in Arms___ Lights Bother Eyes___
Loss of Smell___ Cold Sweats___ Nervousness___ Loss of Memory___
Pins & Needles in legs___ Loss of Taste___ Fever___ Tension____ Numbness in fingers__
Ears Ring___ Diarrhea___ Other____

23. Did you have any physical complaints BEFORE THE ACCIDENTS? If so describe in detail:____
____

24. Please describe how you felt:

a) During the accident: ____
b) Immediately after the accident:____________________________________
c) Later that day:____
d) The next day:____

25. What are you present complaints and symptoms?____________________________
____
____

26. Have you lost time from work as a result of this accident?___ If yes, please complete these questions:

a. Last day worked:____
b. Type of employment:____
c. Present salary:____
d. Are you being compensated for time lost from work?_______ If yes, please state type of compensation you are receiving:__________________________

27. Do you notice any activity restrictions as a result of this injury?___ If yes, please describe, in detail:____
____

Previous History

28. Do you have any congenital (from birth) factors which relate to this problem?_______
If yes, please describe:____
____

29. Do you have any previous illness which relate to this case?____ If yes, please describe:____
____

30. Have you ever been involved in an accident before?________If yes, please describe, including date(s) and type(s) of accidents, as well as injury(ies) received:_____________
____
____

31. Have you been awarded prior workers compensation or personal injury settlement?
____

32. Other pertinent information:____
____
____