

# Personal Injury Questionnaire

Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Age \_\_\_\_\_ Birthdate \_\_\_\_\_ Sex \_\_\_\_\_ SS# \_\_\_\_\_

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 \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Policy Holder's Name \_\_\_\_\_ Policy # \_\_\_\_\_

## ATTORNEY

Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Were there any witnesses?  Yes  No If yes, 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. 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 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(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 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 ACCIDENT:

- |  |   |  |  |  |
|--|---|--|--|--|
| <input type="checkbox"/> Headache          | <input type="checkbox"/> Irritability           | <input type="checkbox"/> Numbness in Toes    | <input type="checkbox"/> Face Flushed    | <input type="checkbox"/> Feet Cold     |
| <input type="checkbox"/> Neck Pain         | <input type="checkbox"/> Chest Pain             | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Buzzing in Ears | <input type="checkbox"/> Hands Cold    |
| <input type="checkbox"/> Neck Stiff        | <input type="checkbox"/> Dizziness              | <input type="checkbox"/> Fatigue             | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Stomach Upset |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Head Seems Too Heavy   | <input type="checkbox"/> Depression          | <input type="checkbox"/> Fainting        | <input type="checkbox"/> Constipation  |
| <input type="checkbox"/> Back Pain         | <input type="checkbox"/> Pins & Needles in Arms | <input type="checkbox"/> Lights Bother Eyes  | <input type="checkbox"/> Loss of Smell   | <input type="checkbox"/> Cold Sweats   |
| <input type="checkbox"/> Nervousness       | <input type="checkbox"/> Pins & Needles in Legs | <input type="checkbox"/> Loss of Memory      | <input type="checkbox"/> Loss of Taste   | <input type="checkbox"/> Fever         |
| <input type="checkbox"/> Tension           | <input type="checkbox"/> Numbness in Fingers    | <input type="checkbox"/> Ears Ring           | <input type="checkbox"/> Diarrhea        | <input type="checkbox"/> _____         |

Symptoms Other Than Above \_\_\_\_\_

21. Have you lost time from work as a result of this accident?  Yes  No 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?  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