Personal Injury Questionnaire

Name _____ Phone _____
Home Address _____
City, St. Zip _____
Birth date _____ Age _____ SS # _____
Employer _____ Phone _____
Employer Address _____
City, State, Zip _____

Responsible Party Information

Responsible Party _____
Policy Holders Name _____
Primary Insurance Co. _____
Insurance Co Address _____
City, State, Zip _____
Agent's Name _____ Phone _____
Claim # _____ Fax # _____

Your Insurance Company Information

Insurance Co. _____
Insurance Co. Address _____
City, St. Zip _____ Phone _____
Agent's Name _____ Fax # _____

Attorney Information

Name _____ Phone _____
Firm's Name _____
Address _____
City, State, Zip _____

Nature of Accident

1) Date of Accident _____ Time of Day _____
2) Were you Driver / Passenger Front Seat / Back Seat
3) No. of passenger involved _____ Were you wearing seatbelts? Yes / No
4) What direction were you headed? North / South / East / West
Name of Street, City, State _____
5) What direction was the other vehicle headed? North / South / East / West
Name of Street _____
6) Were you struck from… Front / Rear / Left Side / Right Side
7) Approximate speed of your car _____ Speed of the other car _____
8) Were you knocked unconscious? Yes / No
9) Were the police notified? Yes / No
10) Were there any witnesses? Yes / No
11) In your words, please describe the accident _____

_____

_____

_____

_____

12) Did you have any physical complaints **before** the accident? Yes / No If yes, please describe below

_____

_____

_____

Personal Injury Questionnaire

Please describe how you felt:

During the accident _____

Immediately after _____

Later that day _____

Next day _____

14) What are your current complaints and symptoms? _____

_____

_____

15) Do you have any congenital (from birth) factors which relate to this problem? Yes / No

1f yes, please describe _____

_____

16) Do you have any previous illnesses which relate to this case? Yes / No

_____

17) Have you ever been involved in an accident before? Yes / No

_____

_____

18) Where were you taken after the accident? _____

19) Have you been treated by another doctor since the accident? Yes / No

Doctor's name: _____

Address: _____

Treatment received? _____

_____

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	___ 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	___ Other

Other symptoms _____

21) Since the injury, are your symptoms: Improving Getting Worse Same

22) Have you lost time from work as a result of this accident? Yes / No

Last day worked _____ Type of Employment_____

Present Salary _____ Compensation for loss of Work? Yes / No

If yes, please describe _____

23) Do you notice any activity restrictions as a result of this injury? Yes / No If yes, please describe below

_____

_____

_____

24) Other information _____

_____

_____

_____

_____ _____

Date Patient's Signature