# Personal Injury Questionnaire

Name ________________________________________________Phone (     ) __________________
Address__________________________________City _________________ State ______Zip_______
Age _________ Birth Date ___________________ Sex_____________ S/S#______________________
Employer's Name _________________________ Employer's Address__________________________
Your Insur. Co. ______________________ Policy # ________________ Agent's name ___________
Name on Policy (If other than self) ______________________________________________________
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. 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 the 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 accident:_____________________________________________________________
_____________________________________________________________________________
b. Immediately after the accident:_______________________________________________
_____________________________________________________________________________
c. Later that day:______________________________________________________________
_____________________________________________________________________________
d. The next day: ______________________________________________________________
_____________________________________________________________________________

13. What are you 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), 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 doctors name and address:

________________________________________________________________________________

What time of treatment did you receive? __________________________________________

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

20. CHECK SYMPTOMS YOU HAVE NOTICED SINCE 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 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 ________ |

Symptoms Other Than Above: ______________________________________________________

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