PERSONAL INJURY QUESTIONNAIRE

Name_____ Date of Injury_____ Phone_____

Address_____ City_____ State_____ Zip_____

Employer's Name_____ Employer's Address_____

Your Ins. Co._____ Policy#_____ Agent's Name_____

Driver/Other Vehicle_____ Ins.Co._____ Policy#_____

Have you retained an attorney? ( ) Yes ( ) No Name_____

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?_____ Other Vehicle_____
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. Were you knocked unconscious? ( )Yes ( )No If yes, for how long?_____
   _____
8. Were police notified? ( )Yes ( )No
9. In your own words, please describe accident:_____
   _____
   _____
   _____
10. Did you have any physical complaints BEFORE THE ACCIDENT? ( )Yes ( )No. If
    yes, please describe in detail: _____
    _____
    _____
11. Please describe how you felt:
    a. DURING the accident:_____
    b. IMMEDIATELY AFTER the accident:_____
    c. LATER THAT DAY:_____
    d. THE NEXT DAY:_____
12. What are your PRESENT complaints and symptoms?_____
    _____
    _____

13. Do you have any congenital (from birth) factors which relate to this problem? ( )Yes ( )No If yes, please describe:_____

_____

14. Do you have any previous illnesses which relate to this case? ( )Yes ( )No If yes, please describe:_____

_____

15. 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._____

_____

_____

16. Where were you taken after the accident?_____

17. Have you been treated by another doctor since the accident? ( )Yes( )No If yes, please list doctor's name and address:_____

_____

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

19. CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT:

( )Headache	( )Irritability	( )Numbness in Toes
( )Neck Pain	( )Chest Pain	( )Shortness of Breath
( )Neck Stiff	( )Dizziness	( )Fatigue
( )Sleeping Problems	( )Head Seems Too Heavy	( )Depression
( )Back Pain	( )Pins & Needles in Arms	( )Lights Bother Eyes
( )Nervousness	( )Pins & Needles in Legs	( )Loss of Memory
( )Tension	( )Numbness in Fingers	( )Ears Ring
( )Feet Cold	( )Hands Cold	( )Stomach Upset
( )Constipation	( )Cold Sweats	( )Fever
	( )_____	

Symptoms Other Than Above _____

20. Have you lost time from work as a result of this accident? ( )Yes ( )No. IF yes, please complete this question.

    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:_____

_____

21 Do you notice any activity restrictions as a result of this injury? ( )Yes ( )No If yes, please describe, in detail:_____

_____

_____

22. Other pertinent information:_____

_____

Date_____ Patient's Signature_____