# PERSONAL INJURY QUESTIONNAIRE

## INFORMATION ABOUT YOU

Name _____ Phone _____

Address _____ City _____ State _____ Zip _____

Age _____ Birthdate _____ Sex ( ) M ( ) F S/S # _____

Employer's Name and Address _____

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

Name on Policy (if other than self) _____

Responsible Party's Name _____

Address _____ City _____ State _____ Zip _____

Insurance Co. and Policy # _____

## INFORMATION ABOUT YOUR ATTORNEY

Name _____ Phone _____ Fax: _____

Address _____ City _____ State _____ Zip _____

Were there any Witnesses? ( ) Yes ( ) No Names _____

## INFORMATION ABOUT YOUR 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? (Yes) (No)
4. What direction were you headed? ( ) North ( ) East ( ) South ( ) West
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 the accident: _____

_____

_____

11. Did you have any physical complaints BEFORE THE ACCIDENT? ( ) Yes ( ) No
    If yes, describe: _____

_____

12. Please describe how you felt:
    a. DURING the accident: _____
    b. IMMEDIATELY after the accident: _____
    c. LATER that day: _____
    d. NEXT day: _____

13. What are your PRESENT complaints and symptoms? _____

_____

_____

14. Do you have any congenital (from birth) factors which relate to this problem? _____

_____

_____

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 injuries received:

_____

17. Where were you taken after the accident? _____

18. Have you been treated by another doctor since the accident? ( ) Yes ( ) No

If yes, names: _____

_____

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

20. CHECK SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT:

| | | | | |
|---|---|---|---|---|
| ( ) HEADACHE | ( ) IRRITABILITY | ( ) NUMBNESS-TOES | ( ) FACE FLUSHED | ( ) FEET COLD |
| ( ) NECK PAIN | ( ) CHEST PAIN | ( ) SHORTNESS-BREATH | ( ) BUZZING IN EARS | ( ) HANDS COLD |
| ( ) NECK STIFF | ( ) DIZZINESS | ( ) FATIGUE | ( ) LOSS OF BALANCE | ( ) STOMACH UPSET |
| ( ) SLEEPING PROBLEM | ( ) HEAD IS HEAVY | ( ) DEPRESSION | ( ) FAINTING | ( ) CONSTIPATION |
| ( ) BACK PAIN | ( ) PIN/NEEDLES ARMS | ( ) LIGHT SENSITIVE EYES | ( ) LOSS OF SMELL | ( ) COLD SWEATS |
| ( ) NERVOUSNESS | ( ) PINS/NEEDLES LEGS | ( ) LOSS OF MEMORY | ( ) LOSS OF TASTE | ( ) FEVER |
| ( ) TENSION | ( ) NUMBNESS-FINGER | ( ) EARS RING | ( ) DIARRHEA | |

Symptoms other than above _____

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

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, 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: _____

23. Other pertinent information: _____

_____

_____

_____ _____

Date Patient's Signature