PERSONAL INJURY QUESTIONNAIRE

Name_____ Date of Accident_____ Time_____

Your Ins. Co. _____ Claim #_____ Agents Name_____

Driver/Other Vehicle Ins. Co._____ Claim #_____

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

Were you: ( ) Driver ( ) Passenger ( ) Front Seat ( ) Back Seat

Make of your vehicle_____ Make of other vehicle_____

What direction were you headed? ( ) North ( ) South ( ) East ( ) West

On (name of street)_____

What direction was the other vehicle heading? ( ) North ( ) South ( ) East ( ) West

On (name of street)?_____

Approximate speed of your vehicle_____ Approximate speed of other vehicle_____

Were you struck from: ( ) Behind ( ) Front ( ) Driver side ( ) Passenger side

Were you wearing a seatbelt? ( ) Yes ( ) No Shoulder harness? ( ) Yes ( ) No

Did you strike anything in vehicle at time of impact? ( ) Yes ( ) No If yes, specify_____

Were police notified? ( ) Yes ( ) No Do you have a copy of the police report? ( ) Yes ( ) No

Please describe accident: _____

_____

_____

_____

Immediately following the accident, how did you feel? _____

_____

_____

_____

Were you knocked unconscious? ( ) Yes ( ) No Did you go to the hospital? ( ) Yes ( ) No

If so, were you taken by ambulance? ( ) Yes ( ) No ( ) Other_____

If so, name of hospital _____ Were you x-rayed? ( ) Yes ( ) No

What treatment was rendered? _____

_____

Describe the symptoms from the day following the accident to today's date:

_____

_____

_____

Since the accident occurred, are your symptoms: ( ) Improving ( ) Getting Worse ( ) Same

Check Symptoms you have noticed since the accident:

( ) Headaches	( ) 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 problem	( ) Head seems to heavy	( ) Depression	( ) Fainting	( ) Constipation
( ) Back Pain	( ) Pins & needles in arms	( ) Light bothers eyes	( ) Loss of smell	( ) Cold Sweats
( ) Nervousness	( ) Pins & Needles in legs	( ) Loss of memory	( ) Loss of taste	( ) Fever
( ) Tension	( ) Numbness if fingers	( ) Ears ring	( ) Diarrhea	( ) Other_____

Have you lost time from work as a result of this accident? ( ) Yes ( ) No Last day worked? _____

Do you notice any activity restrictions as a result of this injury? ( ) Yes ( ) No

If yes, describe in detail: _____

_____

_____

Did you have any physical complaints BEFORE the accident? ( ) Yes ( ) No

If yes, please describe: _____

_____

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

If yes, please describe: _____

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

If yes, please describe. Include date(s), type of accident, as well as injury(s) received: _____

_____

_____

_____ _____

Patient's Signature Date