PERSONAL INJURY QUESTIONNAIRE

Information about You

Name _____ Phone_____

Address _____ City _____ State _____ Zip _____

Age _____ Birthdate _____ Sex ◯F ◯M SSN: _____

Employer's Name _____ Employer's Address _____

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

Name on Policy (if other than self) _____

Responsible Party's Name _____ Policy Nr _____

Address _____ City _____ State _____ Zip _____

Policy Holder's Name _____

Information about Your Attorney

Name _____ Ph _____ Fx _____

Address _____ City _____ State _____ Zip _____

Were there any witnesses? ◯ Yes ◯ No Names _____

Information about Your Accident

Date of Accident _____ Time of Day _____

Were you: ◯ Driver ◯ Passenger ◯ Front Seat ◯ Back Seat

Number of people in your vehicle? _____ Were you wearing seatbelts? ◯ Yes ◯ No

What direction was you headed? ◯ North ◯ East ◯ West ◯ South

What direction was the other vehicle headed? ◯ North ◯ East ◯ West ◯ South

On (name of street) _____

Were you struck from: ◯ behind ◯ front ◯ Left Side ◯ Right Side

Approximate speed of your car _____ mph Other car _____ mph

Were you knocked unconscious? ◯ Yes ◯ No If yes, for how long? _____

Were policy notified? ◯ Yes ◯ No

In your own words, please describe the accident: _____

_____

_____

Did you have any physical complaints before the accident? ◯ Yes ◯ No

If yes, please describe: _____

_____

_____

Please describe how you felt:

During the accident: _____

Immediately after the accident: _____

Later that day: _____

The next day: _____

What are your present complaints and symptoms? _____

_____

_____

Where were you taken after the accident? _____

Have you been treated by another doctor since the accident? ◯ Yes ◯ No

If yes, please write down their names: _____

Since the injury occurred, are your symptoms ◯ improving ◯ getting worse ◯ Same

CHECK SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT:

☐ Headache	☐ Irritability	☐ Numbness in toes	☐ Flushed face
☐ Neck pain	☐ Chest pain	☐ Shortness of breath	☐ Buzzing in ears
☐ Stiff neck	☐ Dizziness	☐ Fatigue	☐ Loss of balance
☐ Difficulty sleeping	☐ Head is heavy	☐ Depression	☐ Fainting
☐ Back pain	☐ Pin/Needles in arms	☐ Light sensitive eyes	☐ Loss of smell
☐ Nervousness	☐ Pin/Needles in legs	☐ Loss of memory	☐ Loss of taste
☐ Tension	☐ Numbness in fingers	☐ ringing ears	☐ Diarrhea
☐ Cold feet	☐ Cold hands	☐ Upset stomach	☐ Constipation
☐ Cold sweats	☐ Fever	☐ _____	☐ _____

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

_____

_____

Do you have any previous illnesses that relate to this case? ◯ Yes ◯ No

If yes, please describe: _____

_____

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

If yes, please describe, including date(s) and type(s) of accident(s) as well as injuries suffered:

_____

_____

_____

Have you lost time from work as a result of this accident? ◯ Yes ◯ No

Last day worked: _____

Type of Employment: _____

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

If yes, please describe: _____

_____

Other pertinent information: _____

_____

_____ _____

Date Patient's Signature