Personal Injury Questionnaire

Name: _____ Phone: _____

Address:_____ City:_____ State:____ Zip:_____

Age:_____ Birthdate: ___/___/____ Sex: M___ F___ SS#_____

Employer's Name:_____ Employer's Address:_____

Your Ins. Co.:_____ Policy #:_____

Agent's Name:_____ Name on Policy:_____

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:

Date of Accident:_____ Time of Day: _____

Were you: Driver____ Passenger___ Front Seat___ Back Seat___

Number of people in your vehicle_____ Were you wearing seat belts?_____

What direction were you headed? North__ South__ East__ West__ on 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 Police notified? Yes__ No__

In your own words, please describe accident: _____

_____

_____

_____

Did you have any physical complaints BEFORE THE ACCIDENT? Yes____ No_____

If yes, Please describe in detail: _____

_____

_____

_____

Please describe how you felt:

a. DURING the accident:_____
b. IMMEDIATELY AFTER the accident:_____
c. LATER THAT DAY:_____
d. THE NEXT DAY:_____

What are your PRESENT complaints and symptoms:_____

_____

_____

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

If yes, Please describe in detail: _____

_____

Do you have any previous illnesses that relate to this case? Yes___ No___

If yes, Please describe in detail: _____

_____

Have you ever been involved in an accident before? Yes___ No___

If yes, Please describe including date(s), type(s) of accident, as well as injury(ies) received:

_____

_____

_____

Where were you taken after the accident?_____

Have you been treated by another doctor since the accident? Yes___ No___

If yes, Please list Doctor's name and address: _____

_____

_____

What type of treatment did you receive? _____

_____

_____

Since the injury occurred are your symptoms: Improving____ Worsening____ Same____

Check symptoms you have noticed since the accident:

☐ Headache	☐ Irritability	☐ Numbness in Toes	☐ Face Flushed	☐ Cold Feet
☐ Neck Pain	☐ Chest Pain	☐ Shortness of Breath	☐ Buzzing in Ears	☐ Cold Hands
☐ Neck Stiff	☐ Dizziness	☐ Fatigue	☐ Loss of Balance	☐ Stomach Upset
☐ Sleeping Problems	☐ Head Seems Too Heavy	☐ Depression	☐ Fainting	☐ Constipation
☐ Back Pain	☐ Pins & Needles, Arms	☐ Lights Bother Eyes	☐ Loss of Smell	☐ Cold Sweats
☐ Nervousness	☐ Pins & Needles, Legs	☐ Loss of Memory	☐ Loss of Taste	☐ Fever
☐ Tension	☐ Numbness in Fingers	☐ Ears Ring	☐ Diarrhea	☐ Other

Symptoms other than above:_____

Have you lost time from work as a result of this accident? Yes__ No__ If yes, please complete:

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:_____

Did you notice any activity restrictions as a result of this injury? Yes___ No___

If yes, Please describe in detail: _____

_____

Other pertinent information? _____

_____