PERSONAL INJURY QUESTIONAIRE

NAME_____ D.O.B_____ PHONE#_____
ADDRESS_____ CITY_____ STATE_____ ZIP _____
EMPLOYER'S NAME_____
EMPLOYERS ADDRESS _____
YOUR INS. CO._____ POLICY#_____ AGENTS NAME _____
DRIVER/OTHER VEHICLE_____ INS. CO._____ POLICY# _____
HA VE YOU RETAINED AN ATTORNEY? (◉) Y (◯) N NAME _____
WE RE THERE ANY WITNESSESS? (◯) Y (◉) N NAME _____

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 (street) _____
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) WERE YOU KNOCKED UNCONSCIOUS?_____ IF YES HOW LONG? _____
8) WERE POLICE NOTIFIED? _____
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? _____
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? _____
IF YES LIST DOCTOR'S NAME AND ADDRESS AND WHAT TYPE OF TREATMENT.

_____

_____

_____

18) SINCE THIS INJURY OCCURRED, ARE YOUR SYMPTOMS:
(◯) IMPROVING (◯) GETTING WORSE (◯) SAME

19) HAVE YOU LOST TIME FROM WORK AS A RESULT OF THIS ACCIDENT? (◉) YES (◯) NO
IF YES, PLEASE COMPLETE THE FOLLOWING QUESTIONS
a) Last day you worked:_____
b) Type of Employment: _____
c) Are you being compensated for your time lost?_____ If yes, state type of compensation you are receiving:_____

20) DO YOU NOTICE ANY ACTIVITY RESTRICTIONS AS A RESULT OF THIS INJURY?_____
IF YES, PLEASE DESCRIBE IN DETAIL:

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21) OTHER PERTINENT INFORMATION:

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_____

PATIENT NAME_____SIGN_____

DATE _____