

## PERSONAL INJURY QUESTIONNAIRE

### INFORMATION ABOUT YOU

Name \_\_\_\_\_ Phone \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Age \_\_\_\_\_ Birthdate \_\_\_\_\_ Sex ( ) M ( ) F S/S # \_\_\_\_\_  
Employer's Name \_\_\_\_\_ Employer's Address \_\_\_\_\_  
Your Ins. Co. \_\_\_\_\_ Policy # \_\_\_\_\_ Agent's Name \_\_\_\_\_  
Name on Policy (if other than self) \_\_\_\_\_ Policy # \_\_\_\_\_  
Responsible Party's Name \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Policy Holder's Name \_\_\_\_\_

### 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. THE 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:**

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

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 ( ) N

If yes, type of compensation you are receiving: \_\_\_\_\_

22. Do you notice any activity restrictions as a result of this injury? ( ) Yes ( ) N

If yes, please describe: \_\_\_\_\_

\_\_\_\_\_

23. Other pertinent information: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Date

Patient's Signature