PERSONAL INJURY QUESTIONNARE

Name: ____ Date: ___________________

Address: ________________________________ Home Phone#_________________________

Date of Birth: __________________ Sex: ______________ S.S: _________________________

Employer's name: ______________________ Address & Phone: __________________________

Auto Insurance: __________________ Phone: _______________ Policy: ___________________

Policy Holder (if other that yourself): _________________________________

Attorney's name: _______________________ Phone: __________________

NATURE OF ACCIDENT:

1. Date Of the Accident:___________________ Time of Day: _______________
2. Were you: ( )Driver ( )Passenger ( )Front Seat ( )Back Seat
3. Number of People in your vehicle:________ Were you wearing a seat belt:_______
4. Where direction were you headed: ( )North ( )South ( )East ( )West
5. Name of the street you were on: _____________________________________
6. What direction was the other vehicle headed : ( )North ( )South ( )East ( )West
7. Named the street the other vehicle was on: ______________________________
8. Where you struck from: ( )Behind ( )Front ( )Left Side ( )Right Side
9. Were Police notified? ( )Yes ( )No
10. In your own word please described the accident: _______________________________________

    ____

    ____

    ____

11. Did you have any physical complaints BEFORE THE ACCIDENT? ( ) Yes ( ) No. If yes, please describe

    ____

    ____

    ____

12. Please describe how you felt:
    a. DURING the accident:____
    b. IMMEDETELY AFTER the accident:____
    c. LATER THAT DAY of the accident:____
    d. THE NEXT DAY of the accident:____

13. What are you PRESENT complains and symptoms? ____

____

14. Did you have any congenital (from birth) factors which relates to this problem? ( )Yes ( )No. If yes, explain:

____

____

15. Do you have any previous illnesses which relate to this case? ( )Yes ( )No. If yes, describe them:

____

____

16. Have you ever been involved in an accident before? ( )Yes ( )No. If yes, please explain and include (date, type and injury for the accident): ____

____

____

17. Where were you taken after this accident? ____

18. Have you been treated by another doctor since this accident? ( )Yes ( )No If yes, please list the doctor's name and address:____

19. Since this injury are your symptoms: ( )Improving ( )Getting worse ( )Same

20. CHECK SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT:

☐ Headache	☐ Irritability	☐ Numbness in Toes	☐ Face Flushed	☐ Feel Cold
☐ Neck Pain	☐ Chest Pain	☐ Shortness of Breath	☐ Buzzing Ears	☐ Hands Cold
☐ Neck Stiff	☐ Dizziness	☐ Fatigue	☐ Loss of Balance	☐ Stomach Upset
☐ Sleeping Problems	☐ Head Seems Too Heavy	☐ Depression	☐ Fainting	☐ Constipation
☐ Back Pain	☐ Pins & Needles in Arm	☐ Lights Bother eyes	☐ Loss of Smell	☐ Cold Sweats
☐ Nervousness	☐ Pins & Needles in Leg	☐ Loss of memory	☐ Loss of Taste	☐ Fever
☐ Tension	☐ Numbness in Fingers	☐ Ears ring	☐ Diarrhea	☐ _______________

Symptoms Other than above: ____

21. Have you lost time from work as a result of this accident? ( )Yes ( )No. If yes, please answer the following:

a. Last day worked: ____

b. Ty of employment: ____

c. Present Salary: ____

d. Are you being compensated for time lost at work? ( )Yes ( )No. If ye, please state type of compensation you are receiving: ____

22. Do you notice any activity restrictions as a result of this injury? ( )Yes ( )No If yes, explain:_____________

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23. Other pertinent information:____

____

Patient's Signature: ____________________________________ Date: ______________________________