Personal Injury Questionnaire

Date ______________________________

Name ______________________________ Home Phone ______________________
Address ______________________________ City ____________State _______ Zip Code ________
Cellular Phone ______________________ E-mail ______________________________
Age ________ Birth Date _________ Marital Status: M S W D How many Children? ______________
Occupation ______________________________ Employer______________________________
Address ______________________________ Office Phone______________________
Insurance Company ______________________ Agents Name______________________
Policy # ______________________________ Social Security No ______________________
Name of Spouse ______________________ Birth Date______________________
Employer______________________________ Office Phone______________________

ATTORNEY

Name ______________________________ Phone ______________________
Address ______________________________ City ____________ State _______ Zip ________

Were there any witnesses? ☐ YES ☐ NO Names(s) ______________________________

NATURE OF ACCIDENT:

1. Date of Accident ________________ Time of Day ________________☐ AM ☐ PM
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 ☐ South ☐ East ☐ West
   On (name of street) ______________________________
5. What direction was the other vehicle headed? ☐ North ☐ South ☐ East ☐ 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 the police notified?☐ YES ☐ NO
10. In your words, please describe the accident: ______________________________
    ____
    ____
11. Did you have any physical complaints BEFORE THE ACCIDENT? ☐ YES ☐ NO If yes, please describe in detail: ____
    ____
    ____
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 case? ☐ YES ☐ NO If yes, please describe: ____

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 injury(ies) received. ______________________
____
____

17. Where were you taken after the accident? __________________________________

18. 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? ______________________________________
____

19. Since the accident occurred, are your symptoms: ☐ Improving ☐ Getting Worse ☐ Same

20. CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT:

☐ Headaches	☐ Dizziness	☐ Light Bothers Eyes	☐ Diarrhea
☐ Neck Pain	☐ Head seems too Heavy	☐ Loss of Memory	☐ Feet Cold
☐ Neck Stiffness	☐ Pins and Needles in Arms	☐ Ears Ring	☐ Hands Cold
☐ Sleeping Problems	☐ Pins and Needles in Legs	☐ Face Flushed	☐ Stomach Upset
☐ Back Pain	☐ Numbness in Fingers	☐ Buzzing in ears	☐ Constipation
☐ Nervousness	☐ Numbness in Toes	☐ Loss of Balance	☐ Cold Sweats
☐ Tension	☐ Shortness of Breath	☐ Fainting	☐ Fever
☐ Irritability	☐ Fatigue	☐ Loss of Smell	☐ ______________
☐ Chest Pain	☐ Depression	☐ Loss of taste	☐ ______________

Symptoms other than above ____

21. Have you lost time from work as a result of this accident? ☐ YES ☐ NO If yes, please complete this question
    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: ______________________________

22. Do you notice any activity restriction as a result of this injury? ☐ YES ☐ NO If yes, please describe, in detail: ____
____
____

23. Other pertinent information: ____
____
____
____

______________________ ______________________________

Date Patient's Signature