PERSONAL INJURY QUESTIONNAIRE

Name _____ Date of Injury _____ Phone _____

Address _____ City _____ State _____ Zip _____

Employer's Name _____ Employer's Address _____

Your Ins. Co. _____ Policy # _____ Agent's Name _____

Driver/Other Vehicle _____ Ins. Co. _____ Policy # _____

Have you retained an attorney? ◯ Yes ◯ No Name _____

Were there any witnesseass? ◯ Yes ◯ No Name(s) _____

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 (name of street) _____
5. What direction was 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? ◯ Yes ◯ No. If yes, for how long? _____
8. Were police notified? ◯ Yes ◯ No
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? ◯ Yes ◯ No. 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? ◯ Yes ◯ No. If yes, please list doctor's name and address: _____

What type of treatment did you receive? _____

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 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: _____

20. Do you notice any activity restrictions as a result of this injury? ◯ Yes ◯ No. If yes, please describe, in detail: _____

21. Other pertinent information: _____

_____ DATE

_____ PATIENT'S SIGNATURE