PERSONAL INJURY QUESTIONNAIRE

Date: ___________________

PERSONAL INFORMATION

Name ____ Phone (   ) _________________________

Address __________________________________ City______________________ State ________ Zip__________

Age __________ Birthdate __________________ Sex _______ SS# ______________________________________

Your Insurance Company __________________________________ Policy # ____________________________

Name on Policy (if other than self) __________________________ Agent's Name _____________________

Responsible Party's Name _______________________ Insurance Company __________________________

Address _________________________________ City ______________________ State ________ Zip __________

Policy Holder's Name ______________________________________ Policy # ____________________________

ATTORNEY

Have you appointed an attorney? YES ____ NO _____

If yes, Name ____ Phone (   ) _____________________________

Address ________________________________ City _____________________ State __________ Zip __________

NATURE OF ACCIDENT

1. Date of accident _______________________ Time of Day ___________________________
2. Were you the: ______ Driver ______ Passenger ______ Front Seat ______ Back Seat
3. How many other passengers? ____
4. What type of Vehicle were you in? __________ Make __________ Model __________ Year
5. What type of vehicle was other care? __________ Make __________ Model __________ Year
6. Was the pavement: ______ Dry ______ Wet ______ Snowy ______ Icy ___________ Other
7. Were you wearing a lap & shoulder seat belt? _____ Yes _____ No
8. Does your vehicle have an integrated headrest? _____ Yes _____ No
9. Were police notified? _____ Yes _____ No
10. Was the vehicle Totaled? _____ Yes _____ No
11. Were there any witnesses? _____ Yes _____ No

    Names: ____

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12. Was your head rotated? _____ Yes _____ No if yes: _____ Right _____ Left
13. Were you knocked unconscious? _____ Yes _____ No If yes, how long: __________________
14. What direction were you headed? _____ North _____ East _____ South _____West

    On (name of Street) ____
15. Direction other vehicle was headed? _____ North _____ East _____ South _____ West

    On (name of Street) ____
16. Were you struck from: _____ Behind _____ Front _____ Side _____ Left _____ Right
17. Your approximate speed: _______mph
18. Other car's approximate speed: _______ mph
19. In your own words, please describe the accident: ____

    ____

    ____

    ____
20. Did you have any physical complaints prior to accident? _____ Yes _____ No

    If yes, please describe in detail: ____

    ____

    ____
21. Please describe how you felt immediately after the accident: ______________________________

    ____
22. Please describe how you felt the next day: ____

    ____
23. Please describe your current complaints and symptoms: ___________________________________

    ____

    ____
24. Do you have any congenital factors, which relate to this problem? _____Yes _____ No

    If yes, please describe: ____

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25. Do you have any previous illnesses, which relate to this case? _____ Yes _____ No

    If yes please describe: ____

26. Have you ever been involved in an accident before? _____ Yes _____ No

    If yes, please include date(s), type(s) of accident, as well as injury(ies) received: ____________

    ____

    ____

27. Where were you taken after the accident? ____

28. Have you been treated by another doctor since the accident? _____ Yes _____ No

    If yes, please list doctor name, specialty and treatment received: __________________________

    ____

    ____

29. Are you currently taking any medication? _____ Yes _____ No

    If yes, please list all medications and if they are a result of your accident complaints:

    ____

    ____

30. Since this injury occurred, are your symptoms: _____ Improving _____ Worse _____ Same

31. CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT:

☐ Headache	☐ Neck Pain	☐ Stiff Neck	☐ Back Pain	☐ Nervousness
☐ Tension	☐ Irritability	☐ Chest Pain	☐ Dizziness	☐ Fatigue
☐ Sleeping Problems	☐ Pins & Needles in the Legs	☐ Pins & Needles in the Arms	☐ Numbness in the Fingers	☐ Numbness in toes
☐ Shortness of Breath	☐ Light Sensitivity	☐ Loss of Balance	☐ Upset Stomach	☐ Head feels heavy
☐ Memory Loss	☐ Ringing Ears	☐ Flushed Face	☐ Buzzing Ears	☐ Fainting
☐ Loss of Smell	☐ Loss of Taste	☐ Diarrhea	☐ Cold Feet	☐ Cold Hands
☐ Constipation	☐ Cold Sweats	☐ Fever	☐ Depression	☐ _____________

Symptoms Other than those listed above: ____

____

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32. Have you lost any time from work as a result of this accident? _____ Yes _____ No

    If yes, please state type of compensation you are receiving: ______________________________

    ____

33. Do you notice any activity restrictions as a result of this injury? _____ Yes _____ No

    If yes, please describe: ____

    ____

34. How has this injury impacted your overall enjoyment of life (work, recreation, daily activities, sleep)? ____

    ____

    ____

    ____

    ____

35. Any other pertinent information you think we should know? _______________________________

    ____

    ____

    ____

Patient Signature: ____________________________________ Date: ____________________

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