PERSONAL INJURY QUESTIONNAIRE

Name________________________________ Date of Injury________________________

Your Insurance Company__________________________Agent Name____________________

Address____

Phone____________________ Claim or Policy Number________________________________

Other Driver's Name________________________Claim or Policy #______________________

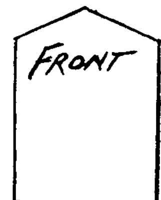
Other Driver's Insurance Company____________________________Phone____________

Have you retained an attorney? [ ] Yes [ ] No If so, please list name, address and phone:

____

Nature of Accident:

1. Date of accident________________________ Time of day_____________________________
2. Location of accident (streets, city, state)____
3. Were you: [ ] driver [ ] passenger [ ] in front seat [ ] in back seat
4. Make & model of your vehicle___________________ Other vehicle______________________
5. Approximately how fast were you going?_______________________________________
   Approximately how fast was other vehicle(s) going?___________________________________
6. Number of people in your vehicle? _________________ Other vehicle?______________________
7. What were the road conditions? [ ] Dry [ ] Wet [ ] Icy
8. What direction were you headed? [ ] North [ ] East [ ] South [ ] West
   On (name of street)____
9. What direction was other vehicle headed? [ ] North [ ] East [ ] South [ ] West
10. Were you struck from: [ ] Behind [ ] Front [ ] Left side [ ] Right side
11. Were you wearing seat belts? [ ] Yes [ ] No Shoulder harness? [ ] Yes [ ] No
12. Did you seat have a headrest? [ ] Yes [ ] No
13. Were you braced for the impact? [ ] Yes [ ] No
14. If you were hit, were you applying the brakes on impact? [ ] Yes [ ] No
15. Which way was your head facing on impact? [ ] Straight ahead [ ] Right [ ] Left
16. Were you knocked unconscious? [ ] Yes [ ] No If yes, for how long? _______________
17. Were police notified? [ ] Yes [ ] No
18. To the right is a picture of the vehicle that was hit. If you were hit, draw the other vehicle, the direction it was traveling and where it hit you. If you hit the other vehicle, draw your vehicle, the direction you were traveling and where you hit the car.



19. In your own words, please describe the accident:_____________________________________

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20. Did you have any physical complaints BEFORE THE ACCIDENT? [ ] Yes [ ] No
If yes, please describe in detail: ______________________________

____

21. What are your PRESENT complaints and symptoms? ______________________________

____

22. Do you suffer from any other disabling condition or physical impairment not due to this accident?
[ ] Yes [ ] No If yes, please explain ______________________________

23. Do you notice any activity restrictions as a result of this injury? [ ] Yes [ ] No
If yes, please describe in detail ______________________________

____

24. Where were you taken after the accident? ______________________________

25. Did you require post-accident hospitalization? [ ] Yes [ ] No

26. What treatment was given? ______________________________

27. Have you been treated by another doctor since the accident? [ ] Yes [ ] No
If yes, please give doctor's name ______________________________
What type of treatment did you receive? ______________________________

____

28. Since this injury occurred, are you symptoms: [ ] improving? [ ] getting worse? [ ] same

29. CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT:

____ Headache	____ Irritability	____ Numbness in Toes	____ Face Flushed	____ Feet Cold
____ Neck Pain	____ Chest Pain	____ Shortness of Breath	____ Buzzing in ears	____ Hands Cold
____ Neck Stiff	____ Dizziness	____ Fatigue	____ Loss of balance	____ Stomach Upset
____ Sleeping problems	____ Head Seems Heavy	____ Depression	____ Fainting	____ Constipation
____ Back Pain	____ Pins & needles in arms	____ Light bothers eyes	____ Loss of smell	____ Cold Sweats
____ Nervousness	____ Pins & needles in legs	____ Loss of memory	____ Loss of Taste	____ Fever
____ Tension	____ Numbness in fingers	____ Ears ring	____ Diarrhea	____________

Symptoms other than above ______________________________

30. Have you lost time from work as a result of this accident? [ ] Yes [ ] No
(a) Last day worked ______________________________
(b) Date returned to work ______________________________
(c) Type of employment ______________________________

31. Have you ever been involved in an accident before? [ ] Yes [ ] No When? ____________
What were your injuries? ______________________________

____

______________________________ Date

______________________________ Patient Signature