

PERSONAL INJURY QUESTIONNAIRE

Name _____ Date of Birth _____ 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 witnesses? 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. CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT:

- | | | | | |
|--|---|--|--|--|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Irritability: | <input type="checkbox"/> Numbness in Toes | <input type="checkbox"/> Face Flushed | <input type="checkbox"/> Feet Cold |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Buzzing in Ears | <input type="checkbox"/> Hands Cold |
| <input type="checkbox"/> Neck Stiff | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Stomach Upset |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Head Seems Too Heavy | <input type="checkbox"/> Depression | <input type="checkbox"/> Fainting | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Pins & Needles in Arms | <input type="checkbox"/> Lights Bother Eyes | <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> Cold Sweats |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Pins & Needles in Legs | <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Loss of Taste | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Tension | <input type="checkbox"/> Numbness in Fingers | <input type="checkbox"/> Ears Ring | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> _____ |

Symptoms Other Than Above _____

20. 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: _____

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

22. Other pertinent information: _____