PERSONAL INJURY QUESTIONNAIRE

Name _____Phone # ( ) _____Work#( )_____

Cell #_____ Address _____

City_____ State _____ Zip _____

Age _____ Birthday _____ Sex _____ S/S # _____

Employer's Name _____ Employer's Address _____

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

Name on Policy (if other than self) _____ Policy # _____

Responsible Party's Name _____

Address _____ City _____ State _____ Zip _____

Policy Holder's Name _____ Policy # _____

ATTORNEY

Name _____ Phone ( ) _____

Address _____ City _____ State _____ Zip _____

Were there any witnesses? ( ) Yes ( ) No Name(s) _____

NATURE OF ACCIDENT:

1. Date of Accident _____ time of Day _____
2. Were you: ( ) Driver ( ) Front seat passenger ( ) Right back seat ( ) Left back seat.
3. Type of Vehicle: ( ) Car ( ) Van ( ) Pick up truck ( ) Station wagon ( ) Large truck ( ) Bus
4. Number of people in your vehicle? _____ Were you wearing a seat belt? _____.
5. What direction were you headed? ( ) North ( ) East ( ) South ( )West
   Name of street? _____
6. What direction was <u>other</u> vehicle headed? ( ) North ( ) East ( ) South ( ) West
   Name of street? _____
7. Where was your vehicle struck? ( ) Rear ended ( )Left Front ( ) Right Front ( ) Head on
   ( ) Left Rear ( ) Right Rear.
8. What was the direction of your head at time of accident? ( ) Facing forward ( ) Turned to right
   ( ) Turned to left.
9. During the accident did your body strike the inside of the Vehicle? ( ) Yes ( ) No
   If yes please describe_____
   _____
   _____
10. Approximate speed of your car _____mph. Other car _____ mph.
11. Were you knocked unconscious? ( ) Yes ( ) No If yes, for how long? _____.
12. Were police notified? ( ) Yes ( ) No.

13. In your own words, please describe accident: _____
_____
_____
_____
14. Did you see the accident coming? ( )Yes ( ) No
15. Did you brace for the impact? ( ) Yes ( ) No
16. Did your air bags deploy? ( ) Yes ( ) No
17. Damage to Vehicle? ( ) Mild ( ) Moderate ( ) Totaled
18. Damage to other parties Vehicle? ( ) Mild ( ) Moderate ( ) Totaled
19. Visibility at time of accident? ( ) Poor ( ) Fair ( ) Good
20. Road Conditions? ( ) Icy ( ) Wet ( ) Sandy ( ) Clean & Dry
21. Did you have any physical complaints BEFORE the ACCIDENT? ( ) Yes ( ) No. If yes, please describe in detail: _____
_____
_____

22. Please describe how you felt:
    a. During the accident: _____
    _____
    b. Immediately after the accident: _____
    _____
    c. Later that day : _____
    _____
    d. The next day: _____
    _____

23. What are your PRESENT complaints and symptoms? _____
_____
_____

24. Do you have any congenital (from birth) Factors which relates to this problem? ( ) Yes ( ) No
If yes, please describe: _____
_____

25. Do you have any previous Illnesses which relates to this case? ( ) Yes ( ) No If yes, please describe: _____
_____.

26. 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 injuries received. _____
_____
_____.

27. Where were you taken after? ( ) Hospital E.R. ( ) Home ( ) Work ( ) Private Dr.
28. How did you get there? ( ) Drove self ( ) Ambulance ( ) Police officer ( ) Someone else

29. Have you been treated by another doctor since the accident? ( ) Yes ( ) No. If yes, please list doctors name and address: _____

_____

What type of treatment did you receive? _____

_____

_____

30. Since this injury occurred, are your symptoms: ( ) Improving ( ) Getting Worse ( ) Same.

31. CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT:

__ Headache	__ Irritability	__ Numbness in Toes	__ Face Flushed	__ Feet Cold
__Neck Pain	__ Chest Pain	__ Short of Breath	__ Buzzing in Ears	__ Hands Cold
__ Neck Stiff	__ Dizziness	__ Fatigue	__ Loss of Balance	__ Stomach Upset
__ Sleeping Prob	__ Head Heavy	__ Depression	__ Fainting	__ Constipation
__ Back Pain	__ Pins&needles in Arms	__Lights bother eyes	__ Loss of Smell	__ Cold Sweats
__Nervousness	__Pin&needles in Legs	__ Loss of Memory	__Loss of taste	__ Fever
__ Tension	__ Numbness in Fingers	__ Ears Ring	__ Diarrhea	

Other:_____

_____

32. Have you lost time from work as a result of this accident? ( ) Yes ( ) No If yes, please complete these 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_____

    _____

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

    _____

    _____

34. Other pertinent information: _____

    _____

    _____

    _____

    _____

_____ _____

(DATE) (NAME)