PERSONAL INJURY QUESTIONNAIRE

INFORMATION ABOUT YOU

Name _____ Phone _____

Address _____ City _____ State _____ Zip _____

Age _____ Birthdate _____ Sex ( ) M ( ) F SS# _____

Employer's Name _____ Employer's Address _____

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

Responsible Party's Name _____

Address _____ City _____ State _____ Zip _____

Policy Holder's Name _____

INFORMATION ABOUT YOUR ATTORNEY

Name _____ Phone _____ Fax _____

Address _____ City _____ State _____ Zip _____

Were there any Witnesses? ( ) Yes ( ) No. Names _____

INFORMATION ABOUT YOUR ACCIDENT

1. Date of Accident _____ Time of Day _____
2. Were You : ( ) Driver ( ) Passenger ( ) Front Seat ( ) Back Seat
3. Number of people in your vehicle? _____ Were you wearing seat belts? ( ) Yes ( ) No
4. What direction were you headed? ( ) North ( ) East ( ) South ( ) West
5. What direction was the other vehicle headed? ( ) North ( ) East ( ) South ( ) West
   On (name of street) _____
6. Were you struck from: ( ) Behind ( ) Front( ) Left side ( ) Right side
7. Approximate speed of your car _____ mph. Other car _____ mph.
8. Were you knocked unconscious? ( ) Yes ( ) No If yes, for how long? _____
9. Were police notified? ( ) Yes ( ) No
10. In your own words, please describe the accident: _____

_____

_____

11. Did you have any physical complaints BEFORE THE ACCIDENT? ( ) Yes ( ) No
    If yes, describe: _____

_____

_____

12. Please describe how you felt:
    a. DURING the accident: _____
    b. IMMEDIATELY AFTER the accident: _____
    c. LATER THAT DAY: _____
    d. THE NEXT DAY: _____

13. What are your PRESENT complaints and symptoms?

_____

_____

_____

14. Do you have any congenital (from birth) factors which relate to this problem?

_____

_____

15. Do you have any previous illnesses which relate to this case? ( ) Yes ( ) No

If yes, please describe: _____

_____

16. 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:

_____

_____

17. Where were you taken after the accident? _____

18. Have you been treated by another doctor since the accident? ( ) Yes ( ) No

If yes, names: _____

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

20. CHECK SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT.

HEADACHE	IRRITABILITY	NUMBNESS-TOES	FACE FLUSHED	FEET COLD
NECK PAIN	CHEST PAIN	SHORNESS-BREATH	BUZZING IN EARS	HANDS COLD
NECK STIFF	DIZZINESS	FTIGUE	LOSS OF BALANCE	STOMACH UPSET
SLEEPING PROBLEM	HEAD IS HEAVY	DEPRESSION	FAINTING	CONSTIPATION
BACK PAIN	PIN/NEEDLES ARMS	LIGHT SENSITIVE EYES	LOSS OF SMELL	COLD SWEATS
NERVOUSNESS	PIN/NEEDLES LEGS	LOSS OF MEMORY	LOSS OF TASTE	FEVER
TENSION	NUBMNESS-FINGERS	EARS RING	DIARRHEA	_____

Symptoms other than above _____

21. Have you lost time from work as a result of this accident? ( ) Yes ( ) No

a. Last day worked: _____

b. Type of employment: _____

c. Present Salary: _____

d. Are you being compensated for time lost from work? ( ) Yes ( ) No

22. Do you notice any activity restrictions as a result of this injury ( ) Yes ( ) No

If yes, please describe: _____

_____

23. Other pertinent information: _____

_____

_____ _____

DATE **PATIENT'S SIGNATURE**