# PERSONAL INJURY QUESTIONNAIRE

Name ______________________________ Date of Injury ______________ 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 _________________________________

**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. 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. Are you being compensated for time lost from work? ( ) Yes ( ) No. If yes, please state type of compensation you are receiving: ____________________
20. Do you notice any activity restrictions as a result of this injury? ( ) Yes ( ) No. If yes, please describe, in detail:

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

21. Other pertinent information:

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

________________________________ ________________________________
DATE PATIENT'S SIGNATURE