Personal Injury Questionnaire

Please complete this form using your keyboard, then print it using the print function of your browser. You can then sign the form and bring it with you to your first appointment. This form will not be submitted via the Internet, so security is not an issue.

Name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Age: _____ Birthdate: _____ Sex: _____ S/S #: _____

Employer's Name: _____ Employer's Address: _____

Your Insurance Company: _____ Policy #: _____ Agent's 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 ___ 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

   on (name of street): _____

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 accident:_____

_____

_____

11. Did you have any physical complaints BEFORE THE ACCIDENT? ___ Yes ___ No If yes, please describe in detail:

_____

_____

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 related to this problem? ___ Yes ___ No If yes, please
describe:_____

_____

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 injury(ies) received:_____

_____

17. Where were you taken after the accident? _____

18. 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? _____

19. Since this injury occurred, are you symptoms: ___ Improving ___ Getting worse ___ Same

20. Please check or place an “x” next to the 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 too 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: _____

21. 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:_____

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

23. Other pertinent information: _____

Date: _____ Patient's Signature: _____