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?

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13. Do you have any congenital (from birth) factors which relate to this problem?
( ) Yes ( ) No. If yes, please describe: ______________________________________

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14. Do you have any previous illnesses which relate to this case? ( ) Yes ( ) No. If yes, please describe:

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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.

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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:

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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:

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21. Other pertinent information:

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______________________ ______________________
DATE PATIENT'S SIGNATURE