PERSONAL INJURY QUESTIONNAIRE

Name ______________________ Phone (   ) ______________

Address ______________________ City ______________ State ______ Zip ______

Age ________ Date of Birth ______________ Sex ______ SS# ______________

Employer's Name ______________________ Address ______________________

Your Ins. Co. ______________ Policy ______________ Agents Name ______________

Ins. Co. Telephone Number ______________ Claim # ______________

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 your seat belts? ______
4. What direction were you headed? (   )North (   )South (   )East (   )West
5. Direction other vehicle headed? (   )North (   )South (   )East (   )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 unconscience? (   )Yes (   )No If yes, how long? ______
9. Were the 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, 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 relate 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: ____

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____

16. Where were you taken after the accident (recent)? __________________________

____

____

17. Have you been treated by another doctor since this accident? ( )Yes ( )No

If yes, please list doctor's name and address: ______________________________

____

____

18. What type of treatment did you receive?__________________________________

____

____

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

20. CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT:

- ❏ Headache
- ❏ Neck Pain
- ❏ Neck Stiff
- ❏ Sleeping Problems
- ❏ Low Back Pain
- ❏ Tension
- ❏ Irritability
- ❏ Chest Pain
- ❏ Dizziness
- ❏ Head Seems Too Heavy
- ❏ Pins & Needles In Arms
- ❏ Pins & needles In Legs

Patient Signature: ______________________________ Date: ______________

Guardian Signature (if patient is a minor): ______________________ Date: ______________