

## PERSONAL INJURY QUESTIONNAIRE

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Phone \_\_\_\_\_ Cell \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Employer \_\_\_\_\_ Employer's Address \_\_\_\_\_ Phone \_\_\_\_\_

Your Auto Ins. Co. \_\_\_\_\_ Policy # \_\_\_\_\_ Agent's Name \_\_\_\_\_ Phone \_\_\_\_\_

Have you opened a claim? ( ) Yes ( ) No Claim # \_\_\_\_\_

**Third Party Payor:** (Must be approved by Practitioner) **Other Driver Name** \_\_\_\_\_

Other Driver's Auto Insurance Co. \_\_\_\_\_ Agent's Name \_\_\_\_\_ Phone \_\_\_\_\_

Claim # \_\_\_\_\_ State Accident Occurred in \_\_\_\_\_

Have you retained an attorney? ( ) Yes ( ) No Name \_\_\_\_\_

Were there any witnesses? ( ) Yes ( ) No Name(s) \_\_\_\_\_

**Your Vehicle:** Year \_\_\_\_\_ Make \_\_\_\_\_ Model \_\_\_\_\_ Speed you were driving \_\_\_\_\_

**Other Vehicle:** Year \_\_\_\_\_ Make \_\_\_\_\_ Model \_\_\_\_\_ Speed of other vehicle \_\_\_\_\_

### **Nature of Accident:**

1. Date of Accident \_\_\_\_\_ Time of Day \_\_\_\_\_ Number of people in your vehicle \_\_\_\_\_

2. Were you: ( ) Driver ( ) Passenger ( ) Front Seat ( ) Back Seat Wearing Seatbelt? ( ) Yes ( ) No

3. What direction were you headed? ( ) North ( ) South ( ) East ( ) West On (Street Name) \_\_\_\_\_

4. What direction was the other vehicle headed? ( ) North ( ) South ( ) East ( ) West On (Street Name) \_\_\_\_\_

5. Were you struck from ( ) Behind ( ) Front ( ) Left Side ( ) Right Side

6. Were you knocked unconscious? ( ) Yes ( ) No If yes, for how long? \_\_\_\_\_

7. Were Police Notified? ( ) Yes ( ) No Were you examined by a medic? ( ) Yes ( ) No If yes, what treatment were you given?  
\_\_\_\_\_

8. In your own words, please describe the accident  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

9. Did you experience any of the following from the accident (please circle):

Confusion    Disorientation    Light headedness    Dizziness    Nausea    Blurred vision    Ringing/buzzing in ears

If you are still experiencing any of these symptoms, which ones? \_\_\_\_\_

10. Are you currently suffering from any of the following (please circle):

Restlessness    Irritability    Difficulty Concentrating    Memory Loss    Forgetfulness    Sleeplessness    Headache    Neck Pain    Midback Pain

Low back Pain    Nervousness    Chest Pain    Pins and Needles in Arms or Legs    Numbness in Fingers or Toes    Fatigue    Depression    Cold Hands

Cold Feet    Light Sensitivity    Loss of Balance    Diarrhea    Constipation    Reduced tolerance to heat    Reduced tolerance to Alcohol

11. Please describe other complaints and symptoms:

---

---

---

---

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

---

---

---

13. Have you ever been involved in an accident before?  Yes  No If yes, please describe, including date(s) and type(s) of accidents:

---

---

---

14. Have you lost time from work/school as a result of this accident?  Yes  No If yes,

Last day worked \_\_\_\_\_ Type of Employment \_\_\_\_\_ Present Salary \_\_\_\_\_

Are you being compensated for time lost from work?  Yes  No If yes, what is your compensation? \_\_\_\_\_

15. Do you notice any restrictions as a result of this injury?  Yes  No If yes, please describe \_\_\_\_\_

---

---

---

16. Other Pertinent Information \_\_\_\_\_

---

---

---

The information I have given about my health and this motor vehicle accident is accurate and complete.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_