

Name _____ Date of birth _____ 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 Names _____

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: _____

PERSONAL INJURY QUESTIONNAIRE

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: _____

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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 injuries 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 received?

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

19. CIRCLE 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 Problem	Head Seems Too Heavy	Depression	Fainting	Constipation
Back Pain	Pins & Needles in Arms	Lights bother Eyes	Loss of Smell	Cold Sweats
Nervousness	Pins & Needles in Legs	Loss of Memory	Loss of Taste	Fever

PERSONAL INJURY QUESTIONNAIRE

Tension

Numbness in Fingers

Ears Ring

Diarrhea

Symptoms Other Than Above _____

20. 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: _____

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

22. Other pertinent information:

Signature _____ Date: _____

PERSONAL INJURY QUESTIONNAIRE