PERSONAL INJURY QUESTIONNAIRE

Name _____ Date of Birth _____ Phone _____

Address _____ City _____ State ____ Zip _____

Your Auto Ins. Co. _____ Claim # _____ Agent _____

Med-pay Billing Address _____ Phone _____

Have you retained an Attorney? _____ Attorney Name _____

NATURE OF ACCIDENT:

Date of Accident _____ Time of Day _____

Were you (circle): Driver Passenger Front Seat Back Seat

Number of people in vehicle _____ Other Vehicle _____

What direction were you headed (circle)? North East South West

On (name of street) _____

Were you struck from (circle): Behind Front Left Side Right Side

Were you knocked unconscious? _____ If yes, for how long? _____

Were police notified? _____

In your own words, please describe the accident: _____

_____

_____

_____

Did you have any physical complaints BEFORE the accident? _____ If yes, describe in detail: _____

_____

_____

Please describe how you felt: DURING the accident _____

IMMEDIATELY AFTER the accident _____

LATER THAT DAY _____

THE NEXT DAY _____

What are your PRESENT complaints and symptoms? _____

_____

Do you have any congenital (from birth) factors which relate to this problem? _____ If yes, please describe _____

_____

Do you have any previous illnesses which relate to this case? _____ If yes, please describe _____

_____

Have you ever been involved in an accident before? _____ If yes, please describe, including dates and types of

accidents, as well as injuries received _____

_____

Where were you taken after this accident? _____

Have you been treated by another doctor since the accident? _____ If yes, list doctor's name and address _____

_____

What type of treatment did you receive? _____

Since this injury occurred, are your symptoms (circle) Improving Getting Worse Same

CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT:

☐ Headache	☐ Irritability	☐ Numbness in Toes	☐ Face Blushed	☐ 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	☐ Lights bother eyes	☐ Loss of Smell	☐ Cold Sweats
☐ Nervousness	☐ Pins & Needles in Legs	☐ Loss of Memory	☐ Loss of Taste	☐ Fever
☐ Tension	☐ Numbness in Fingers	☐ Ears Ringing	☐ Diarrhea	☐ _____

Symptoms other than above _____

Have you lost time from work as a result of this accident? _____ If yes, last day worked _____

Type of employment _____ Present Salary _____

Are you being compensated for time lost from work? _____ If yes, please state type of compensation you are

Receiving _____

Do you notice any activity restrictions as a result of this injury? _____ If yes, describe _____

_____

Date _____ Patient Signature _____