PERSONAL INJURY QUESTIONNAIRE

Name _____Date of Birth _____ Phone # _____

Address _____City _____ State_____ Zip _____

Your Auto Ins. Co._____Policy # _____ Agent's Name_____

Driver/Other Vehicle _____Ins. Co._____ Policy #_____

Have you retained an attorney? ( ) Yes ( ) No Attorney Name _____Phone_____

Were there any witnesses? ( ) Yes ( ) No Name(s) _____

NATURE OF ACCIDENT

Date of Accident _____Time of Day _____ A.M. / P.M.

In your own words, please describe the accident_____

_____

_____

_____

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

Number of people in your vehicle _____In the other vehicle _____

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

What direction was your vehicle headed? ( ) North ( ) South ( ) East ( ) West on(street name)_____

What direction was the other vehicle headed? ( ) North ( ) South ( ) East ( ) West on(street name)_____

Were you wearing a seatbelt? ( ) Yes ( ) No

Did your body hit anything within the vehicle compartment? ( ) Yes ( ) No _____

Were you knocked unconscious? ( ) Yes ( ) No Were the police notified? ( ) Yes ( ) No

Where were you taken after the accident? _____

Please describe how you felt:

IMMEDIATLEY AFTER the accident _____

LATER THAT DAY _____

THE NEXT DAY_____

What are your PRESENT physical complaints/symptoms? _____

_____

_____

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

Did you have any physical complaints BEFORE THE ACCIDENT? ( ) Yes ( ) No If yes, please describe in detail_____

_____

_____

Have you had any previous illnesses, injuries or accidents that relate to your current complaints? ( ) Yes ( ) No

If yes, please describe _____

_____

Have you been treated by another doctor or health care provider since the accident? ( ) Yes ( ) No

If yes, list the doctor or provider's name and address _____

What type of treatment did you receive? _____

_____

Have you lost time from work due to the accident? ( ) Yes ( ) No

If yes, please complete the questions:

Last Day Worked _____Type of employment_____

Are you being compensated for lost work time? ( ) Yes ( ) No

If yes, what type of compensation _____

Are there any activity restrictions as a result of your injury? ( ) Yes ( ) No

If yes, describe in detail_____

_____

Other pertinent information _____

_____

_____

_____

_____ _____

Patient's Signature Date