Personal Injury Questionnaire

INFORMATION ABOUT YOU

Name:_____Phone#:_____Email:_____

Address:_____City:_____State:_____Zip:_____

Age:_____Birth date:_____Sex ( )M ( )F S/S#:_____-_____-_____

Employers Name:_____Employers Address:_____

Your Ins.:_____POLICY#:_____

Name on Policy (if other than self)_____Agent's Name:_____

Responsible Party's Name:_____Ph#:_____Policy#:_____

Address:_____City:_____State:_____Zip:_____

Policy Holders Name:_____

PLEASE DRAW A MAP OF HOW YOUR ACCIDENT TOOK PLACE:

INFORMATION ABOUT YOUR 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 Seat Belts? ( ) Yes ( ) NO
4. What direction were you headed? ( ) North ( ) East ( ) South ( ) West
5. What direction was the other vehicle headed? ( ) North ( ) East ( ) South ( ) West

On (Name of street) _____

6. Were you struck from ( ) Behind ( ) Front ( ) Left Side ( ) Right Side
7. Approximate speed of your car_____m.p.h. Other Car_____m.p.h._____
8. Were you knocked unconscious? ( ) Yes ( ) No If YES, for how long? _____
9. Were Police notified? ( ) Yes ( ) No
10. In your own words, please describe the accident:_____

_____

_____

11. Did you have any physical complaints *before* this accident? ( ) Yes ( ) No If *yes,* describe:_____
12. **Please describe how you felt:**

a. DURING the accident:_____

b. IMMEDIATELY AFTER the accident:_____

c. LATER THAT DAY:_____

13. What are your PRESENT complains?_____

_____

_____

14. Do you have any congenital (from birth) factors which relate to this problem? ( ) Yes ( ) No

_____

15. Do you have any previous illness which relate to this case? ( ) Yes ( ) No

_____

16. Have you ever been involved in an accident before? ( ) Yes ( ) No

If YES, Please describe, including dates and types of accidents as well as injuries:

_____

_____

17. Where were you taken after this accident?

_____

18. Have you been treated by any doctor, hospital, clinic and/or medical facility since this accident?

If YES names:_____

19. Since the injury occurred are your symptoms ( ) Getting worse ( ) Same

20. CHECK SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT:

Headache: ( ) Yes ( ) No Location:_____ Feet Cold ( )Yes ( ) NO

Buzzing in the Ears: ( ) Yes ( ) No Both ( ) Left ( ) Right ( ) Hands Cold ( ) Yes ( ) NO

Ringing in the Ears: ( ) Yes ( ) No Both ( ) Left ( ) Right ( ) Stomach Upset ( )Yes ( ) NO

Dizziness: ( ) Yes ( ) No Pins & needles hands/ feet ( ) Yes ( ) No Constipation ( )Yes ( ) NO

Nausea: ( ) Yes ( ) No Numbness in hands/ feet ( ) Yes ( ) No Cold Sweats ( ) Yes ( ) NO

Vomiting: ( ) Yes ( ) No Anxious: ( ) Yes ( ) No Loss of taste ( ) Yes ( ) NO

Vertigo: ( ) Yes ( ) No Difficulty Sleeping: ( ) Yes ( ) No Fainting ( ) Yes ( ) NO

Blurry Vision: ( ) Yes ( ) No Photophobia: ( ) Yes ( ) No Face flushed ( ) Yes ( ) NO

Chest Pain: ( ) Yes ( ) No Phobia of driving: ( ) Yes ( ) No Fever ( ) Yes ( ) NO

Abdominal Pain ( ) Yes ( ) No Head is heavy ( ) Yes ( ) No Other:

Problem Breathing: ( ) Yes ( ) No Memory Problem: ( ) Yes ( ) No _____

Cough: ( ) Yes ( ) No Loss Of Balance: ( ) Yes ( ) No _____

Depressed: ( ) Yes ( ) No Weakness of hands/feet ( ) Yes ( ) No _____

Loss Of taste: ( ) Yes ( ) No Diarrhea: ( ) Yes ( ) No _____

Have you lost time from work as a result of this accident? ( ) Yes ( ) No How many days? _____

Last Day Worked:_____ Type of Employment:_____Salary:_____

Do you Notice any activity restriction as a result of this injury/ accident? ( ) Yes ( ) No

Explain:_____

_____ _____

Date: Patient's Signature