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: Depressed: ☐ Yes ☐ No Loss Of Balance: ☐ Yes ☐ No _____

Loss Of taste: ☐ Yes ☐ No Weakness of hands/feet ☐ 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