PERSONAL INJURY QUESTIONAIRE

Name_____Date of Injury_____

Age_____Height_____Weight_____
YOUR Ins. Co._____Claim #_____Claim Adjuster_____
YOUR Ins. Co. Address_____Phone #_____

Driver/Other Vehicle_____Ins. Co_____Claim #_____

Have you retained an attorney? □ Yes □ No Attorneys Name_____

NATURE OF ACCIDENT

Date of Accident_____Time of Day_____
Number of people in YOUR vehicle?_____Other vehicle?_____
YOUR vehicle: Year_____Make_____Model_____
Were police notified? □ Yes □ No Was a report made? □ Yes □ No
What is the estimated cost of damage to the vehicle you were in? _____
Were you wearing a seat belt? □ Yes □ No □ Lap seat belt □ Shoulder/lap seat belt □ Airbag Deployed
Did you receive any injury or bruise from the lap or shoulder seat belt or airbag? □ Yes □ No
If yes, describe_____
What direction were you headed? □ North □ East □ South □ West on (name of street)_____
Road conditions: □ Wet □ Dry □ Icy
At the time of impact, was your vehicle □ stopped □ slowing down □ gaining speed □ traveling at a steady speed
Was the trunk of your body pointed forward at the time of impact? □ Yes □ No If no, how was it turned?
_____
Was your head pointed straight forward? □ Yes □ No If no, what direction was it turned and by how much?
_____
Were you struck from □ Behind? □ Front? □ Left side? □ Right side?
Were you knocked unconscious? □ Yes □ No If yes, for how long?_____
Were you aware of the approaching collision? □ Yes □ No
Was the drivers' foot on the brake? □ Yes □ No If no, estimate the speed_____mph.
Was the OTHER drivers' foot on the brake? □ Yes □ No If no, estimate the speed_____mph.
On what part of the vehicle did your following body parts hit?
Head_____Chest_____
Right/Left shoulder_____Right/Left arm_____
Right/Left hip_____Right/Left leg_____
Right/Left knee_____Other_____
How far is the top of the head restraint or back of the seat from the top of your head (inches)____ □ Above □ Below
Which of the following car parts broke during the collision?
□ Windshield □ Front seat back □ Right/Left side window □ Steering wheel □ Other_____
Where did you go after the accident? □ Emergency room □ Home □ Work □ Other
How did you get there? □ Ambulance □ Your car □ Friends car □ Other
Have you received treatment since the accident? □ Yes □ No Where?_____
What type of treatment did you receive?_____
Have you lost time from work as a result of this accident? □ Yes □ No Last day worked:_____
Are you being paid for time lost from work? □ Yes □ No
If yes, please state type of compensation you're receiving:_____
Do you notice any activity restrictions as a result of this injury? _____
_____

(over please)

Please describe how you felt:

A. DURING the accident_____

_____

B. IMMEDIATELY AFTER the accident_____

_____

C. LATER THAT DAY_____

_____

D. THE NEXT DAY_____

_____

In your own words, please describe the accident:

_____

_____

_____

_____

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 injur(ies) received. _____

_____

_____

Did you have any physical complaints BEFORE THE ACCIDENT? □ Yes □ No If yes, please describe in detail. _____

_____

The OTHER vehicle: Year_____ Make_____ Model_____

At the time of the collision, was it □ Stopped □ Slowing down □ Gaining speed □ Traveling at a steady speed

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

_____

What was the other vehicle's approximate speed?_____

CHECK THE SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT:

□ Headache	□ Restlessness	□ Loss of Smell	□ Stomach upset
□ Neck pain	□ Nervousness	□ Loss of Taste	□ Diarrhea
□ Forgetfulness	□ Sleeping problems	□ Lights bother eyes	□ Constipation
□ Heavy Head	□ Hard to concentrate	□ Face flushed	□ Fever
□ Memory troubles	□ Tension	□ Chest pain	□ Other
□ Disoriented	□ Dizziness	□ Shortness of breath	_____
□ Nauseated	□ Fainting	□ Cold sweats	
□ Blurred vision	□ Irritability	□ Stiff neck	
□ Confused	□ Depression	□ Back pain	
□ Lightheaded	□ Loss of balance	□ Cold hands or feet	
□ Ringing in ear(s)	□ Pins/Needles in arm/leg	□ Numbness (less feeling) in toes or fingers or other_____	
□ Fatigue	□ Reduced tolerance to: □ Heat/Cold □ Alcohol □ Sounds □ Light □ Stress		

Circle the symptoms above you are presently experiencing.

Do you have any pre-existing factors which relate to this/these problem(s)? □ Yes □ No If yes, please describe_____

_____

Date_____Patient Signature_____