Personal Injury Questionnaire

Name ______________________________ Phone ______________

Address ____________________ City __________ State _____ Zip ________

Age ______ Birthdate ______________ Sex _____ Social Security # ______________

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

Nature of Accident

Date of Accident ______________ Time of Day ________

Were you: Driver Passenger Front Seat Back Seat

Number of people in your vehicle? _____ Were you all wearing seat belts? ____________

What direction were you headed? North South East West

Name of Street your vehicle was on? ______________________________

What direction was other vehicle heading? North South East West

Name of street other vehicle was on? ______________________________

Were you struck from: Behind Front Left Side Right Side

Approximate speed of your car? ________ MPH Other car? ________ MPH

Were you knocked unconscious? Yes No If yes, for how long? ____________

Were police notified? Yes No

In your own words describe accident: ______________________________

____

____

Did you have any physical complaints before accident? Yes No If yes, describe in detail: ________

____

Please describe how you felt:

During accident? ______________________________

Immediately after accident? ______________________________

Later that day? ______________________________

Next day? ______________________________

What are your present complaints and symptoms? ______________________________

____

Do you have any previous illnesses that relate to this problem? Yes No

If yes, describe in detail: ____________________

____

Have you ever been involved in an accident before? Yes No If yes, describe, including dates/types of accidents/injuries received: ____________________

____

Where were you taken after the accident? ____________________

Have you been treated by any other doctor since the accident? Yes No If yes, list doctor's names and address: ____________________

____

If yes, what type of treatment did you receive? ____________________

____

Check symptoms you have noticed since accident:

Headachelrritability
Numbness
Face Flushed
Cold Feet
Neck Pain
Pins & needles in arms
Chest Pain
Dizziness
Shortness of breath
Buzzing in Ears
Hands Cold
Neck Stiff
Neck stiff Fatigue
Head seems heavy
Stomach upset
Cold Sweats
Back Pain
Depression
Fainting
Loss of smell
Nervousness
Tension
Ears Ring Fever
Pins & needles in legs
Loss of memory
Loss of taste
Diarrhea

Symptoms other than above? ____________________

Have you lost time from work as a result of this accident? Yes No If yes, complete the following:

Type of work: ____________________

Last day worked: ____________________

Are you being compensated for time lost from work? Yes No

Do you notice any activity restrictions as a result of this inury? Yes No If yes, describe in detail:

____

____

Other information: ____________________

____

____

____________________ ____________________

(date) (signature)