PERSONAL INJURY QUESTIONAIRE

Name_____Date of Birth_____
Person(s) at fault_____
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 wearing a seat belt? _____
What direction were you headed? _____ on (name of street)_____
What direction was other vehicle headed? _____on(name of street)_____
Were you struck from: ( )Behind ( )Front ( )Left Side ( )Right Side
Approximate Speed of your car_____mph Other Car_____mph
Were you knocked unconscious? _____If yes, how long?_____
Were police notified?_____

In your own words, please describe accident:
_____
_____
_____
_____

Did you have any physical complaints or illnesses BEFORE THE ACCIDENT which relate to this case?
( )Yes ( )No If yes, please explain in detail:
_____
_____
_____
_____

Please describe how you felt:
DURING the accident_____
IMMEDIATELY AFTER the accident_____
LATER that day_____
The NEXT day_____

What are you PRESENT complaints and symptoms?
_____
_____
_____
_____

Do you have any congenital (from birth) factors which relate to this problem? ( )Yes ( )No If yes please explain:
_____
_____
_____
_____

Where were you taken after the accident?_____
Have you been treated by another doctor since the accident? If so please list doctor's name and address:

_____
_____

What type of treatment did you receive?

_____
_____

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

Have you ever been involved in an accident before? ( )Yes ( )No If yes, please explain including date and type of accident and injuries.

_____
_____

CHECK SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT:

( )Headache	( )Chest Pain	( )Numbness in fingers or toes	( )Loss of memory	( )Loss of smell or taste
( )Neck Pain	( )Dizziness	( )Shortness of breath	( )Ears ring	( )Diarrhea
( )Neck Stiff	( )Head seems too heavy	( )Fatigue	( )Face flushed	( )Feet or hands cold
( )Sleeping Issues	( )Pins and needles in arms or legs	( )Depression	( )Buzzing in ears	( )Stomach upset
( )Back Pain		( )Light Bothers eyes	( )Loss of balance	( )Constipation
( )Nervousness			( )Fainting	( )Fever
( )Tension				
( )Irritability				

( )Other_____

Have you lost time from work since the accident?_____ If yes, please complete these questions:
Last Day Worked _____
Type of Employment_____
Are you being compensated for time lost from work? _____
If yes, please explain the type of compensation you are receiving _____

Do you notice any activity restrictions as a result of this injury? _____
If yes, please
explain_____
_____
_____

Other pertinent information:

_____
_____
_____
_____

_____ _____
Date Patient Signature