PERSONAL INJURY QUESTIONNAIRE

INFORMATION ABOUT YOU

Name_____ DOB_____ Age _____ Sex M / F
Address _____
City _____ State_____ Zip _____
Home # _____ Work # _____ SS# _____
Employer_____Position/Duties_____

YOUR AUTO INSURANCE INFO:

Your Ins. Co _____ Policy # _____ Agents name _____
Name on policy (if other than self) _____

Claim #: _____ **Name of Adjuster:** _____
Phone #: _____

INSURANCE INFO. ON AT FAULT VEHICLE INVOLVED IN ACCIDENT:
Policy Holder Name:_____
Ins. Co. _____ Name of Adjuster: _____
Claim #: _____ Phone #: _____

PERSONAL HEALTH INSURANCE: (Please provide your personal insurance information)

Ins Co. _____ Phone # _____
Name on policy _____ Policy Holder Date of birth: _____
Ins ID # _____

INFORMATION ABOUT YOUR ATTORNEY:

Name _____ Phone #_____ Fax _____
Address _____City _____ State _____ Zip _____

INFORMATION ABOUT YOUR ACCIDENT:

1. Date of accident _____ Location _____ Time of day _____
2. Name of street _____
3. Were you: ( ) Driver ( ) Passenger ( ) Front seat ( ) Back seat
4. Number of people in your vehicle? _____
5. Were you wearing seat belts? ( ) Yes ( ) No
6. What direction were you headed? ( ) North ( ) South ( ) East ( ) West
7. Direction of other vehicle? ( ) North ( ) South ( ) East ( ) West
8. Were you struck from ( ) Behind ( ) Front ( ) Left side ( ) Right side
9. Approximate speed of your car _____ mph type of vehicle _____
10. Speed of other car _____ mph type of vehicle _____
11. Were you knocked unconscious? ( ) Yes ( ) No If yes, for how long?_____
12. Were police notified? ( ) Yes ( ) No
13. Were there any witnesses? ( ) Yes ( ) No
14. In your own words, please describe the accident _____
    _____
    _____

15. Please describe how you felt:

a. During the accident: _____

b. Immediately after the accident: _____

c. Later that day: _____

d. The next day: _____

16. Where were you taken after your current accident? _____
_____

17. Have you been treated by another doctor(s) since this accident? ( ) Yes ( ) No
If yes, please give name of doctor and type of treatment received:
i. _____ iii. _____
ii. _____ iv. _____

18. Did you have any physical complaints before the accident? ( ) Yes ( ) No
If yes, describe _____
_____

19. What are your present complaints and symptoms? _____
_____
_____
_____

20. Since this injury occurred are your symptoms ( ) Improving ( ) Getting worse ( ) Same

21. **CHECK ALL SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT**

( ) headache	( ) irritability	( ) numbness-toes	( ) face flushed	( ) feet cold
( ) neck pain	( ) chest pain	( ) shortness breath	( ) buzzing in ears	( ) hands cold
( ) neck stiff	( ) dizziness	( ) fatigue	( ) loss of balance	( ) stomach upset
( ) sleep prob.	( ) head heavy	( ) depression	( ) fainting	( ) constipation
( ) back pain	( ) pins/needles-arms	( ) light sens. eyes	( ) loss of smell	( ) cold sweats
( ) nervousness	( ) pins/needles-legs	( ) loss of memory	( ) loss of taste	( ) fever
( ) tension	( ) numbness-finger	( ) ears ring	( ) diarrhea	

( ) Symptoms other than above _____

22. Have you lost time from work as a result of this accident? ( ) Yes ( ) No

a. Last day worked: _____
b. Type of employment: _____

23. Do you notice any activity restrictions as a result of this injury? ( ) Yes ( ) No
If yes, please describe _____
_____
_____
_____
_____

24. Please illustrate how the accident happened.