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PERSONAL INJURY QUESTIONNAIRE

PATIENT INFORMATION

Patient Name ______________________ Date of Injury ______________

Do you have **Personal Injury Protection** under your auto policy? ❑ Yes ❑ No

Your Auto Insurance's Name ________________ Address ______________________________

Adjuster's Name ______________ Phone # ( ) ____________ Policy #__________________

Name of Insured ___________________ Name of Driver ________________________

Claim # ____________________ **Have you retained an attorney?** ❑ Yes ❑ No

Attorney's Name ______________ Phone # ( ) ____________

Attorney's Address ____

OTHER PARTY

Auto Insurance's Name ____________________________

Address ____

Their Insurance Agent's Name ______________ Phone # ( ) ____________ Policy Number ____________

Name of Their Insured ____________________ Name of Their Driver ________________

NATURE OF ACCIDENT

Date of accident: __________ Time of day: __________ Were police notified: ❑ Yes ❑ No

Were there witnesses? ❑ Yes ❑ No Name ________________ Phone # ( ) ____________

Were you: ❑ Driver ❑ Passenger ❑ Front Seat ❑ Back Seat

Number of people in your car ______ Type of vehicle ______________________

Number of people in other car ______ Type of vehicle ______________________

Did you have your seatbelt on? ❑ Yes ❑ No Shoulder strap? ❑ Yes ❑ No Did your airbag go off? ❑ Yes ❑ No

Does you car have a headrest? ❑ Yes ❑ No How high was it adjusted? ________________

Were you struck from: ❑ Behind ❑ Front ❑ Left side ❑ Right side

Did you see accident prior to impact? ❑ Yes ❑ No Or caught by surprise? ❑ Yes ❑ No

What position was your body in at impact? ____________________

Did you feel any popping, tearing, or other noises in you neck or back? ❑ Yes ❑ No

Did any part of you body strike any part of your car? ❑ Yes ❑ No What part? ____________

Were you stunned or knocked unconscious? ❑ Yes ❑ No How long? ________________

Did you find any bruises? ❑ Yes ❑ No Where? __________ Any pain? ❑ Yes ❑ No Where? ________________

Were you taken by ambulance anywhere after the accident? ❑ Yes ❑ No Where? ________________

DESCRIPTION

In your own words, please describe the accident in detail:

____

____

____

____

____

DESCRIPTION (CONTINUED)

Please describe how you felt:

During the accident ______________________________

Immediately after ______________________________

Later that day ______________________________

The next day ______________________________

What are your present complaints and symptoms?

____

____

Have you seen any other doctors since the accident? ❑ Yes ❑ No Who? ______________

Since the accident are your symptoms: ❑ Improving ❑ Getting worse ❑ Same

Did you have any physical complaints before the accident? ❑ Yes ❑ No What? ______________

Have you ever been involved in an accident before? ❑ Yes ❑ No When? ____________

PLEASE CHECK ALL SYMPTOMS YOU HAVE BEEN EXPERIENCING SINCE THE ACCIDENT

❑ Dizziness	❑ Skull/Head Pain	❑ Upper Back Pain	❑ Low Back Pain	❑ Constipation
❑ Fainting	❑ Head Feels Heavy	❑ Upper Back Stiffness	❑ Low Back Stiffness	❑ Diarrhea
❑ Eye Strain	❑ Headache	❑ Mid-back Pain	❑ Buttock Pain	❑ Digestive Problems
❑ Double Vision	❑ Ringing in Ears	❑ Mid-back Stiffness	❑ Hip Pain	❑ Sinus Trouble
❑ Flushed Face	❑ Neck Pain	❑ Shoulder Stiffness	❑ Leg Pain	❑ Loss of Smell
❑ Loss of Balance	❑ Neck Stiffness	❑ Shoulder Pain	❑ Leg Numbness	❑ Excessive Sweating
❑ Mental Dullness	❑ Nausea/Vomiting	❑ Chest Pain	❑ Shortness of Breath	❑ Loss of Taste
❑ Difficulty Focusing	❑ Sensitive to Light	❑ Painful Breathing	❑ Numb Toes/Feet	❑ Pain at Work
❑ Anxiety	❑ Arm Pain	❑ Rib Pain	❑ Cold Feet	❑ Difficulty Sleeping
❑ Nervousness	❑ Arm Numbness	❑ Palpitations	❑ Pins/Needles in Legs	❑ Depression
❑ Pins/Needles in Arms	❑ Swelling - Where? ______________		❑ Pain Behind Eyes	❑ Numb Hand/Arm
❑ Loss of Memory	❑ Irritability	❑ Cold Hands	❑ Fatigue	❑ Tremors
❑ Tension	❑ Difficulty Rising to Walk		❑ Long Car Rides	

Any Difficulty in Prolonged: ❑ Sitting ❑ Standing ❑ Walking ❑ Bending ❑ Lifting ❑ Twisting

EMPLOYMENT

Have you lost time from work due to the accident? ❑ Yes ❑ No If yes, Last day worked __________

Type of Employment ______________

Do you have any work restrictions as a result of the accident? ❑ Yes ❑ No

If yes, please explain:

____

____

SIGNATURE

Your Signature: ______________________ Date: __________

Print Name: ______________________