Personal Injury Questionnaire

Full Name:________________________________ DOB:____/____/______ Phone:________________

Nature of Accident:

What was the cause of injury? ☐Automobile vs Automobile ☐ Automobile vs Object ☐Slip, Trip or Fall

Date of Accident:_____/_____/_____Time of Day:____:_____PM/AM Where you: ☐Driver or ☐Passenger

Number of people in your vehicle?________Number of people in the other vehicle?________________

What direction were you headed? N S E W Direction of other vehicle heading? N S E W

What was the name of the street or intersection?____________________________________

Did you make contact with the interior of the vehicle? ☐Yes ☐No If so, list the parts of the body that came in contact:____

What part of the interior made contact with body?___________________________________

Did you receive an injury to the head? ☐Yes ☐No Did you lose consciousness? ☐Yes ☐No

Where was the impact on your vehicle? ☐Front ☐Front/Passenger Side ☐Front/Driver Side ☐Rear ☐Rear/Passenger Side ☐Rear/Driver Side ☐Other_________________________________

In what direction was your vehicle moving?_____________What was the estimated speed?__________

What was your vehicle's damage? ☐Totaled ☐Heavy ☐Moderate ☐Slight ☐No damage

In what direction was the other vehicle moving?_______________What was the estimated speed?___________

What was the other vehicle's damage? ☐Totaled ☐Heavy ☐Moderate ☐Slight ☐No damage

Was your vehicle towed from the scene? ☐Yes ☐No ☐Other_________________________

Was EMS on the Scene? ☐Yes ☐No Did you go to the Hospital? ☐Yes ☐No ☐Other Facility

If so, what was done for you there? ☐X-Ray ☐CT Scan ☐MRI ☐Other___________________

Who was cited for the accident?____

Describe the accident:____

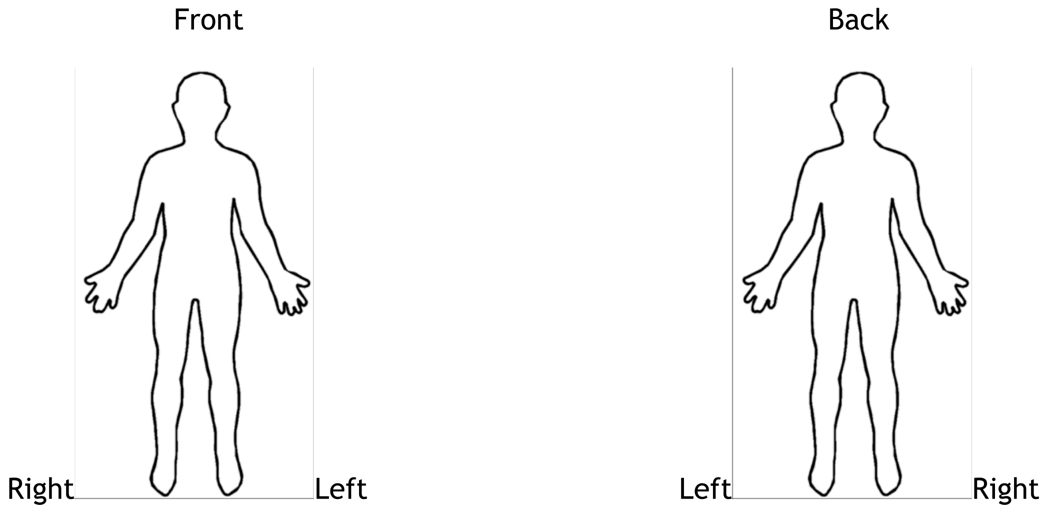
____

Symptoms and Complaints:

Describe the discomfort you felt at the time of the accident. Circle all that apply:

Aching Burning Deep Dull Sharp Shock-Like Stabbing Stiffness Throbbing Tightness Tingling Numbness Other____

Where were the symptoms felt at the time of the accident? Please shade the body:



Did you have any additional symptoms at the time of the accident (supplemental)? Circle all that apply:

Headache Anxiety Breathing Difficulty Chest Pain Depression Dizziness Exhaustion Facial Pain Irritability Loss of Appetite Low Energy Muscle Spasm Numbness and Tingling Rib Pain Sleeping Difficulty Soreness Stomach Pain Stress Tightness Tiredness Other____

Have you missed work due to the accident? ☐Yes ☐No

If yes, list days missed:____

Type of employment:____

Do you notice any activity restrictions as a result of this injury? ☐Yes ☐No

If yes, explain:____