PERSONAL INJURY QUESTIONNAIRE

Full Name:_____DOB: __/__/__ Phone:_____

Address:_____City:_____State:____Zip:_____

Employer's Name:_____Empolyer's Address:_____

Your Auto Ins:_____Policy #:_____Agent Name/Contact:_____

Name of other driver:_____Other Driver Auto Ins:_____Policy:_____

Have you retained an attorney? ( ) yes ( ) no Name:_____Phone:_____

Were there witnesses? ( ) yes ( ) no Names:_____Phone:_____

Nature of Accident

Date of Accident: __/__/__ **T**ime of Date: __:__ PM/AM **W**ere you: ( ) Driver ( ) Passenger ( ) Front ( ) Back

Number of people in your vehicle?_____ **O**ther Vehicle?_____ **W**hat direction were you headed? N S E W **W**hat was

the name of the street?_____ **W**hat direction was the other vehicle headed? N S E W **W**hat was the

name of the street?_____ **W**ere you struck from: ( ) behind ( ) front ( ) left side ( ) right side

Where you knocked unconscious? ( ) yes ( ) no **I**f so how long?_____ **W**here the police notified? ( ) yes ( ) no **W**as anyone

cited? ( ) yes ( ) no **D**id the air bag deploy? ( ) yes ( ) no **W**here were you taken after the accident? _____

Did you receive any treatment: ( ) yes ( ) no **H**ave you been treated by another doctor since accident? ( ) yes ( ) no

Describe the accident:_____

_____
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Did you have any physical complaints before the accident: ( ) yes ( ) no
_____

Describe how you felt: **During** the accident:_____ **Immediately** after:_____

Later that day:_____ **Next** day:_____

What are your present complaints and symptoms**:**_____

Do you have any congential factors which relate to this problem? ( ) yes ( ) no If yes explain:_____

Do you have any previous illness which relate to this care? ( ) yes ( ) no If yes explain:
_____

Since the injury occurred are you symptoms: ( ) **improving** ( ) **getting worse** ( ) **same**

Check symptoms you have noticed since accident: circle all that apply

headache irritability numbness in toes face flushed feet cold neck pain chest pain hands cold

shortness of breath buzzing in ears neck stiff dizziness fatigue loss of balance stomach upset sleeping problems fainting

head seems too heavy depression constipation back pain pins & needles in arms light bother eyes loss of smell cold sweats nervousness

pins & needles in legs loss of memory loss of taste fever tension numbness in fingers ears ring diarrhea

Have you lost time from work as a result of this accident? ( ) yes ( ) no If yes: Last day worked:_____ Type of

employment:_____ **D**o you notice any activity restrictions as a result of this injury? ( ) yes ( ) no If yes

explain:_____

Any addition information:

_____

_____

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_____