1. Print both pages
2. Please fill in completely with pen.
3. Bring to your first appointment.

PERSONAL INJURY QUESTIONNAIRE

Name_____ Date of Birth _____ Phone _____

Address _____ City _____ State _____ Zip _____

Employer's Name _____ Employer's Address _____

Your Ins. Co. _____ Policy # _____ Agent's Name _____

Driver/Other Vehicle _____ Ins. Co. _____ Policy # _____

Have you retained an attorney? ( ) Yes ( ) No Name _____

Were there any witnesses? ( ) Yes ( ) No Name(s) _____

NATURE OF ACCIDENT:

1. Date of Accident _____ Time of Day _____

2. Were you: ( ) Driver ( ) Passenger ( ) Front Seat ( ) Back Seat

3. Number of people in your vehicle? _____ Other vehicle? _____

4. What direction were you headed? ( ) North ( ) East ( ) South ( ) West

on (name of street) _____

5. What direction was other vehicle headed? ( ) North ( ) East ( ) South ( ) West

on (name of street) _____

6. Were you struck from: ( ) Behind ( ) Front ( ) Left side ( ) Right side Other _____

7. Were you knocked unconscious? ( ) Yes ( ) No If yes, for how long? _____

8. Were police notified? ( ) Yes ( ) No

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

_____

_____

_____

10. Did you have any physical complaints BEFORE THE ACCIDENT? ( ) Yes ( ) No If yes, please describe in detail:

_____

_____

_____

11. Please describe how you felt:

a. DURING the accident: _____

b. IMMEDIALTELY AFTER the accident: _____

c. LATER THAT DAY: _____

d. THE NEXT DAY: _____

12. What are your PRESENT complaints and symptoms? _____

_____

_____

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

_____

14. Do you have any previous illnesses which relate to this case? ( ) Yes ( ) No If yes, please describe: _____

_____

15. Have you ever been involved in an accident before? ( ) Yes ( ) No If yes, please describe, including date(s) and type(s) of accidents, as well as injury(ies) received. _____

_____

_____

16. Where were you taken after the accident? _____

17. Have you been treated by another doctor since the accident? ( ) Yes ( ) No

If yes, please list doctor's name(s) and address(es): _____

What type of treatment did you receive? _____

_____

18. Since this injury occurred, are your symptoms: ( ) Improving ( ) Getting Worse ( ) Same

19. CHECK SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT:

☐ Headache	☐ Irritability	☐ Numbness in Toes	☐ Face Flushed	☐ Feet Cold
☐ Neck Pain	☐ Chest Pain	☐ Shortness of Breath	☐ Buzzing in Ears	☐ Hands Cold
☐ Neck Stiff	☐ Dizziness	☐ Fatigue	☐ Loss of Balance	☐ Stomach Upset
☐ Sleeping Problems	☐ Head Seems Too Heavy	☐ Depression	☐ Fainting	☐ Constipation
☐ Back Pain	☐ Pins and Needles in Arms	☐ Lights Bother Eyes	☐ Loss of Smell	☐ Cold Sweats
☐ Nervousness	☐ Pins and Needles in Legs	☐ Loss of Memory	☐ Loss of Taste	☐ Fever
☐ Tension	☐ Numbness in Fingers	☐ Ears Ring	☐ Diarrhea	☐ _____

Symptoms Other Than Above _____

20. Have you lost time from work as a result of this accident? ( ) Yes ( ) No If yes, please complete this question.

a. Last Day Worked: _____

b. Type of Employment: _____

c. Present Salary: _____

d. Are you being compensated for time lost from work? ( ) Yes ( ) No If yes, please state type of compensation you are receiving: _____

21. Do you notice any activity restrictions as a result of this injury? ( ) Yes ( ) No If yes, please describe, in detail:

_____

_____

_____

22. Other pertinent information: _____

_____

_____

Patient's Signature _____ Date _____