

## Personal Injury Questionnaire

Name \_\_\_\_\_ Age \_\_\_\_\_ Phone ( ) \_\_\_\_\_  
Your Ins. Co. \_\_\_\_\_ Policy # \_\_\_\_\_ Agent's Name \_\_\_\_\_  
Name on Policy (If other than self) \_\_\_\_\_ Policy # \_\_\_\_\_  
Responsible Party's Name \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Policy Holder's Name \_\_\_\_\_ Policy # \_\_\_\_\_

### ATTORNEY

Name \_\_\_\_\_ Phone ( ) \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
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? \_\_\_\_\_
4. What direction were you heading? ( ) North ( ) South ( ) East ( ) West  
on (name of street) \_\_\_\_\_
5. What direction was the other vehicle heading? ( ) North ( ) South ( ) East ( ) West  
on (name of street) \_\_\_\_\_
6. Were you struck from: ( ) Behind ( ) Front ( ) Left Side ( ) Right Side
7. Approximate speed of your car \_\_\_\_\_ mph. Speed of other car \_\_\_\_\_ mph.
8. Were police notified? ( ) Yes ( ) No
9. In your own words, please describe accident: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### DESCRIPTION OF INJURY:

1. Did you have a seat belt on? ( ) Yes ( ) No
2. Did you have a shoulder harness on? ( ) Yes ( ) No
3. Did the seat have a headrest? ( ) Yes ( ) No How high was it adjusted? \_\_\_\_\_
4. Were you head, neck and/or body jerked forcibly backward and forward? ( ) Yes ( ) No
5. Were you head, neck and/or body jerked forcibly side to side? ( ) Yes ( ) No
6. Which direction were you looking upon impact? ( ) Left ( ) Right ( ) Straight
7. Did you strike your head? ( ) Yes ( ) No Where? (e.g. windshield, door) \_\_\_\_\_
8. Did you strike your body? ( ) Yes ( ) No Where? (e.g. steering wheel, dash) \_\_\_\_\_
9. Did you strike your knees? ( ) Yes ( ) No Where? (e.g. dash, console) \_\_\_\_\_
10. Did you strike your arms? ( ) Yes ( ) No Where? (e.g. door, dash) \_\_\_\_\_
11. Were there any cuts, gashes, or bruises on your body? ( ) Yes ( ) No  
Describe: \_\_\_\_\_
12. Did you lose your hat, glasses, contact lenses, or earrings? ( ) Yes ( ) No
13. Were you unconscious? ( ) Yes ( ) No How long? \_\_\_\_\_
14. Were you shaken or stunned? ( ) No ( ) Slightly ( ) Moderately ( ) Severely
15. Were you able to get out of the car under your own power? ( ) Yes ( ) No
16. Were either cars towed from the scene? ( ) Yes ( ) No If yes: ( ) Yours ( ) Other
17. Please describe how you felt:  
a. IMMEDIATELY AFTER the accident: \_\_\_\_\_  
b. LATER THAT DAY: \_\_\_\_\_  
c. THE NEXT DAY: \_\_\_\_\_

### SYMPTOMS:

Check symptoms you have experienced since accident:

- |                   |                            |                         |                     |
|-------------------|----------------------------|-------------------------|---------------------|
| ( ) Headaches     | ( ) Head seems too heavy   | ( ) Dizziness           | ( ) Loss of memory  |
| ( ) Neck pain     | ( ) Pins & needles in arms | ( ) Irritability        | ( ) Fainting        |
| ( ) Neck stiff    | ( ) Pins & needles in legs | ( ) Nervousness         | ( ) Loss of balance |
| ( ) Mid back pain | ( ) Numbness in fingers    | ( ) Depression          | ( ) Loss of smell   |
| ( ) Low back pain | ( ) Numbness in toes       | ( ) Ears ring           | ( ) Loss of taste   |
| ( ) Chest pain    | ( ) Lights bother eyes     | ( ) Shortness of breath | ( ) Fever           |
| ( ) Fatigue       | ( ) Sleeping Problems      | ( ) Upset stomach       | ( ) Vomiting        |

Symptoms other than above: \_\_\_\_\_  
Since this injury occurred, are your symptoms: ( ) Improving ( ) Getting Worse ( ) Same

**MEDICAL CARE:**

*If you have not received any medical care since the accident, skip this section and check here ( )*

1. Were you seen by paramedics at the accident? ( ) Yes ( ) No
2. Did you go to the hospital or doctor following the accident? ( ) Yes ( ) No Name: \_\_\_\_\_
3. How did you get there? ( ) Ambulance ( ) Car
4. Were you examined? ( ) Yes ( ) No Was it thorough? ( ) Yes ( ) No
5. Were you x-rayed? ( ) Yes ( ) No If yes, what areas of your body? \_\_\_\_\_
6. What did the doctors tell you? \_\_\_\_\_
7. Did they give you any treatment? ( ) Yes ( ) No If yes, please describe: \_\_\_\_\_
8. Did they give you any medication? ( ) Yes ( ) No \_\_\_\_\_
9. What follow up advice? \_\_\_\_\_
10. Have you been treated by any other doctors since the accident? ( ) Yes ( ) No  
If yes, please list the doctor's name and address: \_\_\_\_\_
11. Have you received any other medical care up to this point? ( ) Medication ( ) Physical therapy  
Please describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Did it help? \_\_\_\_\_

**PAST MEDICAL HISTORY:**

1. Did you have any physical complaints BEFORE THE ACCIDENT? ( ) Yes ( ) No If yes, please describe in detail: \_\_\_\_\_  
\_\_\_\_\_
2. Do you have any congenital (from birth) factors which relate to this problem? ( ) Yes ( ) No If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_
3. Do you have any previous illnesses which relate to this case? ( ) Yes ( ) No  
If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_
4. Have you had any other accidents which required medical care? ( ) Yes ( ) No. If yes, please describe, including date(s) and type(s) of accidents, as well as injury(es) received: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**DISABILITY:**

1. Have you lost time from work as a result of this accident? ( ) Yes ( ) No  
If yes: Last Day Worked: \_\_\_\_\_ Type of Employment: \_\_\_\_\_
2. Do you notice any activity restrictions as a result of this injury? ( ) Yes ( ) No  
If yes, please describe in detail: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Other pertinent information: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient's Signature