PERSONAL INJURY QUESTIONNAIRE

Has your Auto Insurance company been notified of this accident? _____

Full Name _____ Phone ( ) _____ DATE _____

Your Insurance Co. _____ Agent's Name _____Phone # (___)_____

Policy # _____ Claim # _____ Name on Policy (if other than self) _____

Responsible Party's Name _____ Ins. Co _____ Ph # _____

Address _____ City _____ State _____ Zip _____

Policy Holder's Name (if other than above) _____ Policy # _____

Who will be responsible for today's visit/charges? _____

Emergency Contact _____ Phone # _____ Relation _____

ATTORNEY

Name _____ Phone ( ) _____

Address _____ City _____ State _____ Zip _____

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

_____

_____

DETAILS OF ACCIDENT: Date of Accident: _____ Were you? □ Driver □ Passenger □ Front Seat □ Back Seat

Number of people in your vehicle: _____ Were you wearing a seatbelt(s)? □ Yes □ No Direction Headed: □N □S □E □W

Which direction was the other vehicle headed? □N □S □E □W Where were you struck from? □ Behind □ Front □ Left side □ Right side

Name of Street/ Intersection: _____City_____ County _____State_____

Did you know the accident was about to happen? □ Yes □ No What direction were you looking? _____

Approximate speed of your car _____mph Other car _____ mph **Amount of damage to car $** _____

Were you knocked unconscious? □ Yes □ No If yes, how long? _____ Were police notified? □ Yes □ No

Citation(s) issued? □Yes □No If so, To Whom? _____

In your own words please describe the accident. _____

_____

_____

_____

Did you have any physical complaints BEFORE THE ACCIDENT? □ Yes □ No If yes, describe in detail: _____

_____

_____

_____

Please describe how you felt:

DURING the accident: _____

IMMEDIATELY AFTER the accident: _____

LATER THAT DAY: _____

THE NEXT DAY: _____

What are your present complaints? _____

PERSONAL INJURY QUESTIONNAIRE

Where were you taken after the accident? _____

Have you been treated by another doctor since the accident? □ Yes □ No If yes, please list the doctor's name and address:

_____

What type of treatment did you receive?

_____

_____

_____

Since this injury occurred, are your symptoms: □ Improving □ Getting Worse □ Same

CHECK ADDITIONAL SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT:

□ Neck stiff	□ Loss of hearing	□ Pins and needles in toes	□ Diarrhea	□ Other _____
□ Head seem too heavy	□ Ringing in ears	□ Numbness in Fingers	□ Constipation	
□ Light bother eyes	□ Buzzing in ears	□ Numbness in Toes	□ Sleeping problems	
□ Memory loss	□ Loss of balance	□ Cold hands	□ Nervousness	
□ Face flushed	□ Fainting	□ Cold Feet	□ Tension	
□ Loss of taste	□ Shortness of breath	□ Cold Sweats	□ Irritability	
□ Loss of smell	□ Pins and needles in arms	□ Upset stomach	□ Fever	

Have you lost time from work as a result of this accident? □ Yes □ No If yes, please complete these questions:
Last Day Worked _____ Type of Employment _____ Are you being compensated for time lost from work? Yes / No

If yes, please state type of compensation you are receiving _____

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

_____

_____

_____

Other pertinent information – relating to the accident/injuries:

_____

_____

_____

_____ _____

Date Patient Signature