Personal Injury Questionnaire

Name ______________________ Phone ______________

Home Address ______________________

City, State, Zip ______________________

Birthdate __________ Age ______ SS# ______________

Employer ______________________

Employer Address ______________________

City, State, Zip ______________________

Responsible Party Information

Responsible Party ______________________

Policy Holders Name ______________________

Primary Insurance Co ______________________

Insurance Address ______________________

City, State, Zip ______________________

Agent's Name ______________________ Phone ______________

Claim Number ______________________

Your Insurance Company Information

Insurance Co ______________________

Insurance Address ______________________

City, State, Zip ______________________

Agent's Name ______________________ Phone ______________

Attorney Information

Name ______________________

Insurance Address ______________________

City, State, Zip ______________________

Nature of Accident

1) Date of Accident ______________________ Time of Day ______________
2) Were you Driver or Passenger Front Seat or Back Seat
3) Number of passengers involved __________ Were you wearing seatbelts? Yes or No
4) What direction were you headed? North / South / East / West
5) What direction was the other vehicle headed? North / South / East / West

   Name of Street ______________________
6) Were you struck from… Front / Rear / Left Side / Right Side
7) Approximate speed of your car __________ Speed of the other car __________
8) Were you knocked unconscious? Yes / No
9) Were the police notified? Yes / No
10) Were there any witnesses? Yes / No
11) In your words, please describe the accident? ______________________

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12) Did you have any physical complaints **before** the accident? Yes / No If yes, please describe below

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Personal Injury Questionnaire

Name:____DOB:________________

13) Please describe how you felt:
    During the accident ____
    Immediately after ____
    Later that day ____
    Next day ____

14) What are your current complaints and symptoms? ____

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15) Do you have any congenital (from birth) factors which relate to this problem? Yes / No

If yes, please describe ____

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16) Do you have any previous illness which relate to this case? Yes / No

If yes, please describe ____

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17) Have you ever been involved in an accident before? Yes / No

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18) Where were you taken after the accident? ____

19) Have you been treated by another doctor since the accident? Yes / No
    Doctor's Name: ____
    Address: ____
    Treatment received?: ____

20) 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
___ Sleeping Problems	___ Head seems to heavy	___ Depression	___ Fainting	___ Constipation
___ Back Pain	___ Pins & Needles in Arms	___ Light Bothers 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	___ Other

Other symptoms ____

21) Since the injury, are your symptoms: Improving Getting Worse Same

22) Have you lost time from work as a result of this accident? Yes / No
    Last Day worked ______________________ Type of Employment________________________
    Present Salary ______________________ Compensation for loss of work? Yes / No
    If yes, please describe____

23) Do you notice any activity restrictions as a result of this injury? Yes / No If yes, Please describe below

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I understand and agree that insurance policies are an arrangement between an insurance carrier and myself. I authorize the release of medical information to determine the benefits payable by insurance for related services. Furthermore, I understand that the Doctor's office will prepare any necessary forms and reports to attempt in collection from the Insurance Company for services received and which are customarily covered and related to your personal injury/motor vehicle accident. However, I clearly understand and agree that all services rendered me are charged to my account directly and I am responsible for payment.

Date__________________________ Patient's Signature____