Personal Injury Questionnaire

Name: _____
Address: _____
Phone Number_____ E-Mail_____
Date of Birth: _____

Health Insurance:_____
Phone:_____ ID#_____
Policy Holders Name: _____

Auto Insurance: _____
Phone: _____ ID#_____
Policy Holder's Name: _____
Adjustor's Name: _____Phone: _____
Estimated cost of damages to your vehicle? _____

Have you retained an attorney? Yes___ No___
Attorney's Name: _____
Address: _____
(street) (city) (state) (zip)
Phone: _____

Describe the cause of the injury: (e.g., location of accident/how it happened).
_____
_____
_____

Date of Accident:_____ Time of day/hour of accident_____
Were you: Driver ____ Passenger ____ Front Seat ____ Back Seat ____
Number of people in your vehicle? _____Other Vehicle? _____
Were you struck from: Behind____ Front____ Left Side____ Right Side ____
Were you knocked unconscious? Yes____ No ___ If yes, for how long? _____
Were the police notified? Yes____ No ____
Did you receive a copy of the Police Report? Yes___ No ___
Did you have any physical complaints *before the accident?* Yes___ No___ If yes, describe briefly_____
_____

Please describe how you felt:
During the accident: _____
Immediately after the accident: _____
Later that day: _____
The next day: _____

Name: _____

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

Where were you taken after the accident? _____

Have you been treated by another doctor since the accident? Yes ____ No ____ If yes, please list doctor's name and address _____
What type of treatment did you receive? _____
_____

Since the injury occurred, are your symptoms: Improving ____ Getting Worse ____ Same ____

Please check the symptoms you have noticed since the accident:

__Headache	__Irritability	__Shortness of Breath	__Loss of Balance
__Neck Pain	__Chest Pain	__Fatigue	__Fainting
__Neck Stiff	__Dizziness	__Depression	__Loss of Smell
__Sleeping Problems	__Head seems Too Heavy	__Lights Bother Eyes	__Loss of Taste
__Back Pain	__Pins & Needles in Arms	__Loss of Memory	__Diarrhea
__Nervousness	__Pins & Needles in legs	__Ears Ring	__Feet Cold
__Tension	__Numbness in Fingers	__Face Flushed	__Hands Cold
__Face Flushed	__Numbness in Toes	__Buzzing in Ears	__Stomach Upset
__Constipation	__Cold Sweats	__Fever	

Symptoms other than the above? _____

Have you lost time from work as a result of this accident? Yes____ No____ If yes, please complete the following questions.
Last day worked _____
Name of Employer _____

Do you notice any restrictions as a result of this injury? Yes____ No ____ If yes, please describe in detail _____
_____
_____

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

Patient's Signature: _____ Date: _____