PERSONAL INJURY QUESTIONNAIRE

Name ______________________ Date of Birth ____________ Phone ______________

Address ______________________ City ______________ State _____ Zip ________

Employer's Name ____

Address ____

Phone # ____

Your Insurance Company Name ____

Address ____

Phone # ____

Agent's Name ____

Has a claim been filed Y N (Circle one)

Driver other vehicle Name ____

Insurance Co. Name ____

Address ____

Phone # ____

Agent's Name ____

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

If yes, Name ____

Address ____

Phone # ____

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

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) ____

15. Have you 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?

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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 and address: ______________________________

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What type of treatment did you receive? ______________________________

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

19. *Check the symptoms you have noticed since the accident?*

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

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: ______________________________

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