



## Personal Injury Questionnaire

Name \_\_\_\_\_ Social Security Number \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Home Number \_\_\_\_\_ Mobile \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Employer's Name \_\_\_\_\_ Employer's Address \_\_\_\_\_  
Your Insurance Company \_\_\_\_\_ Policy number \_\_\_\_\_  
Agent's Name \_\_\_\_\_ Agent's Phone Number \_\_\_\_\_  
Claim Number \_\_\_\_\_ Claim Adjuster's Name \_\_\_\_\_  
Claim Adjuster's Phone Number \_\_\_\_\_  
Address to send claims \_\_\_\_\_  
Have you retained an attorney? ( ) Yes ( ) No Name \_\_\_\_\_  
Phone number \_\_\_\_\_  
Attorney's address \_\_\_\_\_

### 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. Type of vehicle you were driving? \_\_\_\_\_ year \_\_\_\_\_ make \_\_\_\_\_ model \_\_\_\_\_
5. Nearest intersection to the accident \_\_\_\_\_
6. What Direction were you headed? ( ) North ( ) East ( ) South ( ) West  
On (name of street) \_\_\_\_\_
7. What direction was the other vehicle headed? ( ) North ( ) East ( ) South ( ) West
8. Were you struck from: ( ) Behind ( ) Front ( ) Left side ( ) Right side
7. Were you rendered unconscious? ( ) Yes ( ) No If yes, for how long? \_\_\_\_\_
9. Were the police notified? ( ) Yes ( ) No! If so, were any citations issued and to whom?  
\_\_\_\_\_
10. In your own words, please describe the accident: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
11. Did you have any physical complaints BEFORE THE ACCIDENT? ( ) Yes ( ) No If yes, please describe in detail: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
12. Please describe how you felt:
  - a. DURING the accident: \_\_\_\_\_
  - b. IMMEDIATELY AFTER the accident: \_\_\_\_\_
  - c. LATER THAT DAY: \_\_\_\_\_
  - d. THE NEXT DAY: \_\_\_\_\_

13. What are your PRESENT complaints and symptoms? \_\_\_\_\_  
\_\_\_\_\_

14. Do you have any congenital (from birth) factors, which relate to this problem?  
( ) No ( ) Yes If yes, please describe: \_\_\_\_\_

15. Do you have any previous illnesses, which relate to this case? ( ) No ( ) Yes. If yes,  
please describe: \_\_\_\_\_

16. Have you ever been involved in an accident before: ( ) No ( ) Yes If yes, please  
describe, including date(s) and Type(s) of accident(s), doctor(s) you treated with, as  
well as injury(s) received.  
\_\_\_\_\_  
\_\_\_\_\_

17. Where were you taken after the accident: \_\_\_\_\_

18. 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? \_\_\_\_\_  
\_\_\_\_\_

19. Since this injury occurred, are your symptoms: ( ) Improving ( ) Getting worse ( ) Same

20. CHECK SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT:

Headache	Irritability	Numbness in Toes	Face Flushed	Cold Feet
Neck Pain	Chest Pain	Shortness of Breath	Buzzing in Ears	Cold Hands
Neck Stiffness	Dizziness	Fatigue	Loss of Balance	Upset Stomach
Sleeping problems	Head seems heavy	Depression	Fainting	Constipation
Back problems	Pins & needles in arms	Light bother eyes	Loss of smell	Cold Sweats
Nervousness	Pins & needles in legs	Loss of memory	Loss of Taste	Fever
Tension	Numbness in Fingers	Ringing in Ears	Diarrhea	_____

Symptoms Other Than Above \_\_\_\_\_ What makes symptoms better or worse?

21. Have you lost time from work as a result of this accident? ( ) Yes ( ) No If yes, please  
complete the following questions:

a. Last day worked: \_\_\_\_\_

b. Type of Employment: \_\_\_\_\_

c. Are you being compensated for time lost from work? ( ) Yes ( ) No If yes,  
please state type of compensation you are receiving: \_\_\_\_\_  
\_\_\_\_\_

22. Do you notice any activity restrictions as a result of this injury? ( ) Yes ( ) No If yes,  
please describe in detail: \_\_\_\_\_  
\_\_\_\_\_

23. Other pertinent information: \_\_\_\_\_  
\_\_\_\_\_

24. Make/Model of your vehicle \_\_\_\_\_

Make/Model of their vehicle \_\_\_\_\_

Did you have your foot on the gas or brake pedal? \_\_\_\_\_

\_\_\_\_\_  
Date

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