PERSONAL INJURY QUESTIONNAIRE

INFORMATION ABOUT YOU…

Name:___________________________ Home Phone: ( )_______________ Cell Phone: ( )_______________

Address:_______________________________________ City:_______________________ State:_____ Zip:____________

Age:____ Birth Date:_______________ Sex: **M or F** S/S#:______-_____-________ DL#____________________

E-mail:________________________________ Occupation:___________________Work Phone: ( )_______________

Employer's Name:_________________ Employer's Address:____

INFORMATION ABOUT YOUR ATTORNEY…

Name:______________________________ Office Phone: ( )_______________ Office Fax: ( )_____________

Address:_______________________________________ City:_______________________ State:_____ Zip:____________

Were there any witnesses? **Yes or No** Names:____

INFORMATION ABOUT YOUR ACCIDENT…

1. Date of Accident:___________________ Time of Day:_______________**a.m. / p.m**. (circle)

2. Were you the: □ **Driver** □ **Front Seat Passenger** □ **Back Seat Passenger** *L R C* □ **3rd Row Seat Passenger** *L R C*

3. Number of people in your vehicle other than yourself?_______ Were you wearing seat belts? **Yes or No**

4. What direction were you headed? □ North □ South □ East □ West
   on:____

5. What direction was the other vehicle headed? □ **North** □ **South** □ **East** □ **West**
   on:____

6. Were you struck from: □ **Front** □ **Behind** □ **Left Side** □ **Right Side**

7. Approximate speed of your car:_______mph. Other car:_____mph. **(*your best estimation of speed*)**

8. Were you knocked unconscious? □ **Yes** □ **No** If yes, for how long?_________________________________

9. Were the police notified? □ **Yes** □ **No** If yes, was a report taken? □ **Yes** □ **No** **Your Case #:**_______________

10. In your own words, please describe the accident:____
____
____
____

11. Did you have any physical complaints ***BEFORE THE ACCIDENT?*** □ **Yes** □ **No**
    If yes, describe:____

12. Please describe how you felt: (*e.g. "I had a dull ache at the back of my neck"*)

    a. **DURING** the accident:____
    b. **IMMEDIATELY AFTER** the accident:____
    c. **LATER THAT DAY**:____
    d. **THE NEXT DAY**:____

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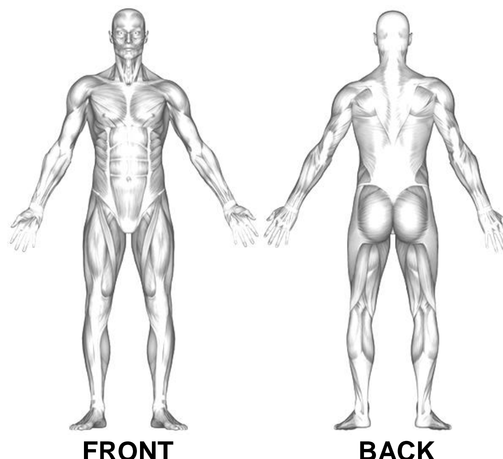
13. What are your **PRESENT** complaints and symptoms?
(***What Hurts the Worst Since Your Accident is #1***)
1.______________________________________
2.______________________________________
3.______________________________________
4.______________________________________

PLACE AN "X" WHERE YOU HAVE PAIN



FRONT **BACK**

14. Do you have any congenital (from birth) factors which relate to this problem? □ **Yes** □ **No**
If yes, please explain:______________________________________
____

15. Do you have any previous illnesses which relate to this case?
□ **Yes** □ **No** If yes, please explain…______________________________
____

16. Have you ever been involved in an accident before? □ **Yes** □ **No**
If yes, please describe, including dates and types of accident as well as injuries received:
____

17. Regarding your current accident, where were you taken after the accident?______________________________

18. Have you been treated by another doctor since the accident? □**Yes** □ **No**
If yes, by whom…____

19. Since the injury occurred, are your symptoms: □ **Improving** □ **Getting Worse** □ **Same**

20. **CHECK SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT:**

□ HEADACHE	□ MID-BACK PAIN	□ IRRITABILITY	□ DIZZINESS	□ BUZZING IN EARS
□ NECK PAIN	□ LOW BACK PAIN	□ FATIGUE	□ EAR RING	□ SLEEP PROBLEMS
□ NECK STIFFNESS	□ GLUTEAL PAIN	□ FAINTING	□ MEMORY LOSS	□ STOMACH UPSET
□ NUMBNESS- FINGERS	□ SHOULDER PAIN	□ LOSS OF SMELL	□ COLD HANDS	□ NERVOUSNESS
□ NUMBNESS- TOES	□ CONSTIPATION	□ LOSS OF TASTE	□ COLD FEET	□ BALANCE LOSS
□ NUMBNESS- ARMS	□ COLD SWEATS	□ DEPRESSION	□ DIARRHEA	□ FEVER
□ NUMBNESS- LEGS	□ CHEST PAIN	□ FACE FLUSHED	□ ___________	□ ______________

Symptoms other than above:____

21. Have you lost time from work as a result of this accident? □**Yes** □ **No**
Last day worked:_______________Type of employment:______________________________
Present salary:_________________ Are you being compensated for time lost from work? □**Yes** □ **No**
If yes, what type of compensation you are receiving: ____________________

22. Do you notice any activity restrictions as a result of this injury? □**Yes** □ **No**
If yes, please explain:____

23. Other pertinent information: ___________________ 24. Past Medical History/Surgery: ________________________
(Female Only) Are you pregnant: __________________

I certify that the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through my provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future.

Patient Signature:____ ***Date***:__________________