

PERSONAL INJURY QUESTIONNAIRE

Complete Name _____ Telephone () _____ Cell Phone () _____

Complete Address _____ City _____ State _____ Zip _____

Age _____ Birth date _____ Gender _____ S/S _____ Marital Status _____

Employer's Name _____ Employer Phone () _____ Occupation _____

Employer's Complete Address _____ City _____ State _____ Zip _____

Your Car Ins. Co. _____ Policy # _____ Agent's Name _____

Policy Holder's Name _____ Claim # _____ Adjuster's Name _____

ATTORNEY

Name _____ Phone () _____

Complete Address _____ City _____ State _____ Zip _____

Were there any witnesses () Yes () No Names(s) _____

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? _____ Were you wearing seat belt(s)? _____

4. What direction were you headed? () North () East () South () West On (what street) _____

5. What direction was the other vehicle headed? () North () East () South () West

6. Were you struck () Behind () Front () Left Side () Right Side

7. Approximate speed of your car _____ mph Other car _____ mph

8. Were you knocked unconscious? () Yes () No If yes, how long? _____

9. Were the police notified? () Yes () No

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 illnesses which relate to this accident? () Yes () No If yes, please describe:

15. Where were taken, if anywhere, after the accident? _____

16. Have you been treated by another doctor since the accident? () Yes () No If yes, please list doctor's name(s) and address: _____

17. What type of treatment did you receive? And what type of results did you get? _____

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

19. CIRCLE SYMPTOMS YOU HAVE NOTICE SINCE THE ACCIDENT:

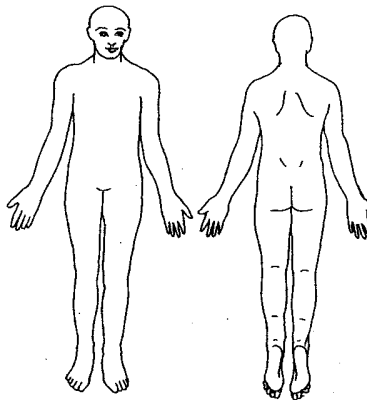
- | | | | | |
|-------------------|------------------------|---------------------|-----------------|---------------|
| Headache | Irritability | Numbness in Toes | Face Flushed | Feet Cold |
| Neck Pain | Chest Pain | Shortness of Breath | Buzzing in Ears | Hands Cold |
| Neck Stiff | Dizziness | Fatigue | Loss of Balance | Stomach Upset |
| Sleeping Problems | Head Seems to Heavy | Depression | Fainting | Constipation |
| Back Pain | Pins & Needles in Arms | Lights Bother 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 | _____ |

20. Have you lost time from work as a result of this accident? () Yes () No If yes, how long? _____

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

22. Have you ever been involved in an accident before? () Yes () No If yes, please describe, in detail: Including dates and treatment received: _____

23. Please mark area(s) affected by the accident on the body.



DATE

PATIENT'S NAME (PLEASE PRINT)

PATIENT'S SIGNATURE