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PERSONAL INJURY QUESTIONNAIRE

Name_____Phone_____

Address_____

Birthdate_____Age_____Sex_____SS#_____

Employer's Name_____ Phone_____

Employer's Address_____

PIP INSURANCE (personal injury protection)

THE FOLLOWING INFORMATION IS FROM THE CAR YOU WERE IN DURING THE ACCIDENT.

Insurance Company_____Phone_____

Address_____

Insured_____Driver_____Relation_____

Policy# _____ Claim# _____ Claim Adjuster _____

ATTORNEY

Name_____Phone_____

Address_____

NATURE OF ACCIDENT

Date of Accident _____Time of day_____AM / PM

Were there any witnesses? _____ If yes Name(s)_____

Number of people in your vehicle? _____Were you wearing a seat belt? _____

What street, town and state did the accident happen in? _____

Road conditions at the time of the accident: WET DRY ICY OTHER_____

What direction were you headed in? ( )North ( )East ( )South ( )West

What direction was other vehicle headed in? ( )North ( )East ( )South ( )West

You were struck from ( )Behind ( )Front ( )Left side ( )Right side

List the year, make and model of the vehicle you were in:
Year _____ make _____ model _____

List the year, make and model of the other vehicle:
Year _____ make _____ model _____

Approximate speed of your car _____mph Other car _____mph

Were the police notified? ( )Yes ( )No Is there a police report? ( )Yes ( )No

In your own words, please describe accident: _____

_____

_____

MECHANICS OF THE ACCIDENT

Was your car stopped at the time of impact? YES NO
If yes, was the driver's foot also on the brake? YES NO
If no, then estimate the speed of the vehicle you were in: _____mph

Where were you seated in the vehicle? _____

What is the approximate distance between the back of your head and your vehicle's headrest?
_____inches

Did your head go back over the top of your vehicle's headrest? YES NO

Were you wearing a seatbelt? YES NO
If yes, was it a lap seatbelt _____ shoulder-lap seatbelt _____

Did you receive any injury or bruise from the seat belt (i.e. breast or abdomen) ?
YES NO
If YES, then describe: _____

Does your vehicle have an airbag? YES NO
Did the airbag deploy in this accident? YES NO
Did you receive an injury from the airbag? YES NO
Please describe: _____

On what part of the automobile did your following body parts hit?
Head hit _____ chest hit_____
Right/left shoulder hit_____ right/left arm hit _____
Right/left hip hit_____ right/left leg hit_____
Right/left knee hit _____ other_____

Was the trunk of your body pointed straight forward at the time of the collision?
YES NO; If no, how was it turned? _____

Was your head pointed straight forward? YES NO; If no, what direction was it turned and by how much?_____

Which of the following car parts broke during the accident? (please circle)

Windshield	front seat back
Right/left side window	other _____
Steering wheel	other _____

What is the estimated cost of the damage to the vehicle you were in? $_____

INJURIES AND TREATMENT

Were you aware of the approaching collision prior to impact, or did impact catch you by surprise?
AWARE SURPRISE

Did you lose consciousness (black out) upon impact? YES NO; How long:_____
Do you remember the actual collision? YES NO

Did you experience a flash of light or explosion in your head? YES NO

Did you go to a hospital? YES NO
If yes, what is the name and city of the hospital?_____
How did you get to the hospital? _____
What parts of your body were x-rayed at the hospital? _____
What did the hospital do for your injuries? _____
How long did you stay at the hospital?_____

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?_____

What bleeding cuts did you sustain during this accident? _____
What bruises did you sustain during this accident? _____

Did you become CONFUSED DISORIENTED LIGHT HEADED DIZZY NAUSEATED BLURRED VISION RING/BUZZ IN EARS from the accident? (please circle)

If you still have any of those symptoms, which ones? _____

Are you currently suffering from any of the following (please circle)

RESTLESSNESS	IRRITABLE
DIFFICULT CONCENTRATING	DIFFICULT WITH MEMORY
SLEEPLESSNESS	FORGETFULNESS
REDUCED TOLERANCE TO HEAT	REDUCED TOLERANCE TO ALCOHOL

Please describe how you felt:

a. DURING the accident: _____

b. IMMEDIATELY AFTER the accident: _____

c. LATER THAT DAY: _____

d. THE NEXT DAY: _____

What are your PRESENT complaints and symptoms? _____

_____

_____

CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT:

___headache	___Irritability	___Numbness in toe	___Face flushed
___Neck Pain	___Chest pain	___Shortness of breath	___Buzzing in ears
___Neck stiff	___Dizziness	___Fatigue	___Loss of balance
___Depression	___Mid Back pain	___ Lower Back pain	___Sleeping problem
___Feet cold	___Hands cold	___Stomach upset	___Constipation
___Nervousness	___Tension	___Loss of smell	___Loss of taste
___Ears Ring	___Diarrhea	___Cold sweats	___Fainting
___Head seems too heavy		___Pins & Needles in arms	___Numbness in fingers
___Pins & Needles in legs		___Lights bothers eyes	___Loss of memory

Symptoms other than above_____

Did you have any physical complaints BEFORE THE ACCIDENT? ( )Yes ( )No

If yes, please describe in detail: _____

_____

_____

_____

Do you have any congenital (from birth) factors that relate to this problem? ( )Yes ( )No

If yes, please describe: _____

Have you lost time from work as a result of this accident? ( )Yes ( ) No

If yes: Last day worked:_____ Type of employment:_____

Are you being compensated for time lost from work? ( )Yes ( )No

If yes, please state type of compensation you are receiving_____

Do you notice any activity restrictions as a result of this injury? ( )Yes ( )No

If yes, please describe, in detail: _____

_____

_____

Other pertinent information: _____

_____

Date _____ Patient's signature _____