Personal Injury Questionnaire

Name _____ Date of Injury _____
Phone_____ Email address _____

Driver/Other Vehicle _____
Insurance Co. _____ Policy no. _____
Have you retained an attorney? _____ Name _____
Were there witnesses? _____ Name(s) _____

Nature of Motor Vehicle 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) _____
5. What direction was the other vehicle headed?
(◯) North (◯) East (◯) South (◯) West on (name of street) _____
6. Were you struck from (◯) Behind (◯) Front (◯) Left side (◯) Right side
7. Were you knocked unconscious?
(◯) Yes (◯) No If so, for how long? _____
8. Were police notified? (◯) Yes (◯) No
9. In your own words, please describe the accident

10. Did you have any physical complaints BEFORE THE ACCIDENT?
(◯) Yes (◯) No If yes, please describe in detail

11. Please describe how you felt:
a) DURING the accident: _____
b) IMMEDIATELY AFTER the accident:
_____
c) Later that day: _____
d) The next day: _____

12. What are your PRESENT complaints and symptoms?

13. Do you have any congenital (from birth) problems that relate to this/ these problem(s)? (◯) Yes (◯) No If yes, please describe:

14. Do you have any previous illnesses that relate to this case?
(◯) Yes (◯) No If yes, please describe:

15. Have you ever 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:

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:

What type of treatment did you receive? _____
Were x-rays taken? (◯) Yes (◯) No If yes, by whom? _____
18. Since the accident occurred, are your symptoms:
(◯) Improving (◯) Same (◯) Getting worse
19. Check symptoms you have noticed since the accident:
Headache (☐) _____
Neck pain (☐) _____
Sleeping problems (☐) _____
Back pain (☐) _____
Nervousness (☐) _____
Tension (☐) _____
Irritability (☐) _____
Chest pain (☐) _____
Dizziness (☐) _____
Head seems too heavy (☐) _____
Pins & needles sensation in arms (☐) _____
Pins & needles sensation in legs (☐) _____
Numbness in fingers (☐) _____
Numbness in toes (☐) _____
Shortness of breath (☐) _____

Fatigue (□) _____
Depression (□) _____
Light bothers eyes (□) _____
Loss of memory (□) _____
Ringing/buzzing in ears (□) _____
Face flushed (□) _____
Loss of balance (□) _____
Fainting (□) _____
Loss of smell (□) _____
Loss of taste (□) _____
Diarrhea (□) _____
Constipation (□) _____
Coldness in feet (□) _____
Coldness in hands (□) _____
Upset stomach (□) _____
Cold sweats (□) _____
Fever (□) _____
Symptoms other than above:

20. Have you lost work as a result of this accident? (○) Yes (○) No
If yes, please explain: a. Type of employment: _____
b. Last day worked: _____
c. Present salary/wage: _____
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:

22. Other pertinent information:

Date: _____ Patient's signature: _____