PERSONAL INJURY QUESTIONNAIRE

Name _____ Phone _____

Address _____ City _____ State _____ Zip _____

Age _____ Birthdate _____ Sex _____ Social Security # _____

Insurance Company _____

Ins. Co. Phone # _____ Claim Adjuster _____

Ins. Co. Address _____ City _____ State _____ Zip _____

Name on policy _____ _____

Policy # _____ Claim # _____ PIP coverage? ☐ Yes ☐ No

Name of Person at Fault _____

Address _____ City _____ State _____ Zip _____

Name of Attorney _____

Address _____ City _____ State _____ Zip _____

Nature of Accident

1. Date of Accident _____ Time of day _____
2. Where were you located in the automobile? _____
3. Number of persons in the automobile _____ Were you wearing a seat belt? ☐ Yes ☐ No
4. Location of accident _____
5. Were you struck from: ☐ Behind, ☐ Front, ☐ Left Side, ☐ Right side
6. Approximate speed of your car _____ mph Other car _____ mph
7. In your own words, please describe the accident: _____

_____

_____

_____

8. Did you have any physical complaints BEFORE the accident? ☐ Yes ☐ No

   If yes, please explain: _____

_____

_____

9. Please describe how you felt:
   a. During the accident _____
   b. Immediately after the accident _____
   c. Later that day _____
   d. The next day _____
10. What are your PRESENT complaints and symptoms: _____

_____

_____

11. Do you have any congenital (from birth) factors which relate to this problem? ☐ Yes ☐ No.

    If yes, please explain: _____

_____

_____

12. Do you have any previous illnesses which relate to this case? ☐ Yes ☐ No

If yes, please explain: _____

_____

13. 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: _____

_____

_____

14. Where were you taken after the accident: _____

15. Have you been treated by another doctor since the accident? ☐ Yes ☐ No

If yes, please explain: _____

_____

_____

16. Since the accident, are your symptoms: ☐ Improving ☐ Getting worse ☐ Same

17. Circle symptoms you have noticed since the accident:

Headache	Shortness of Breath	Stomach upset	Nervousness	Pins/needles in legs
Irritability	Buzzing in Ears	Depression	Loss of Smell	Fever
Numbness in Toes	Hands cold	Head heavy	Pins/needles in arms	Tension
Face flushed	Neck stiff	Sleep Problems	Cold sweats	Diarrhea
Feet cold	Dizziness	Fainting	Nervousness	Loss of memory
Neck pain	Fatigue	Constipation	Fever	Numbness in fingers
Chest pain	Loss of balance	Back Pain	Loss of taste	Ears ring

18. Symptoms noticed other than above: _____

_____

_____

19. Have you lost time from work as a result of this accident? ☐ Yes ☐ No

If yes, please state type of compensation you are receiving: _____

_____

a. Last day worked: _____

b. Type of employment: _____

c. Present salary: _____

d. Are you being compensated for time lost from work? ☐ Yes ☐ No

If yes, please state type of compensation you are receiving: _____

20. Do you notice any activity restrictions as a result of this injury? ☐ Yes ☐ No

If yes, please describe in detail: _____

_____

_____

21. Other pertinent information: _____

_____

_____

_____

_____

Date _____ Patient Signature _____