

PERSONAL INJURY QUESTIONNAIRE

NAME _____ Phone (H) _____ (C) _____
Address _____ City _____ State _____ Zip _____
Email _____ Age _____ Birthdate ___/___/___ Sex M F SS# _____ - _____ - _____
Employer's Name _____ Employer's Addr _____
Your Insurance Co. _____ Policy # _____ Agent's Name _____
Name on Policy (if other than self) _____ Policy # _____
Responsible Party's Name _____
Address _____ City _____ State _____ Zip _____
Policy Holder's Name _____

ABOUT YOUR ATTORNEY

Name _____ Phone _____ Fax _____
Address _____ City _____ State _____ Zip _____
Names of Witnesses (if any) _____

1. Date of Accident _____ Time of Day _____ am/pm () Driver () Passenger Front/Back Seat
2. Number of People in Vehicle _____ Were you wearing your seatbelt? _____
3. What direction were you headed? NORTH SOUTH EAST WEST
4. What direction was the other vehicle headed? NORTH SOUTH EAST WEST
on what street _____
5. You were struck from: BEHIND FRONT RIGHT SIDE LEFT SIDE
6. Estimated Speed of YOUR CAR _____ mph OTHER CAR _____ mph
7. Were you ever unconscious? NO YES For how long? _____
8. Were the Police called? NO YES Was there a report? _____
9. In your own words, describe the accident: _____

10. Where were you taken after the accident? _____

11. Have you been treated by another doctor since the accident? NO YES
If Yes, give names, locations and diagnosis: _____

12. Did you have any physical complaints BEFORE THE ACCIDENT? YES NO
If Yes, please describe: _____

13. Please describe how you felt:
a) DURING the accident: _____
b) IMMEDIATELY after the accident: _____

c) LATER THAT DAY: _____

d) THE NEXT DAY: _____

14. What are your present symptoms and concerns? _____

15. Do you have any previous illnesses that relate to this case? NO YES

If Yes, please describe fully: _____

16. Do you have any congenital (from birth) factors that relate to this problem? _____

17. Have you ever been involved in an accident before? NO YES

If Yes, describe dates and types of accidents, including types of injuries sustained: _____

18. Since the injury occurred, my symptoms are () IMPROVING () GETTING WORSE () THE SAME

19. CIRCLE SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT

HEADACHE	IRRITABILITY	NUMB TOES	FACE FLUSHED	FEET COLD
NECK PAIN	CHEST PAIN	SHORTNESS OF BREATH	BUZZING EARS	HANDS COLD
NECK STIFF	DIZZINESS	FATIGUE	BALANCE LOSS	UPSET STOMACH
SLEEPING PROBLEM	HEAD IS HEAVY	DEPRESSION	FAINING	CONSTIPATION
BACK PAIN	PINS/NEEDLES ARMS	LIGHT SENSATIVE EYES	LOSS OF SMELL	COLD SWEATS
NERVOUSNESS	PINS/NEEDLES LEGS	LOSS OF MEMORY	LOSS OF TASTE	FEVER
TENSION	NUMBNESS FINGERS	EARS RING	DIARRHEA	OTHER _____

Other than above _____

20. Have you lost time from work as a result of the accident? NO YES

a) Last day worked? _____

b) Type of employment: _____

c) Present Salary: _____

d) Are you being compensated for lost time from work? NO YES

If Yes, compensation you are receiving: _____

21. Do you notice any activity restrictions as a result of this injury? NO YES

If Yes, please describe fully: _____

22. Other pertinent information: _____

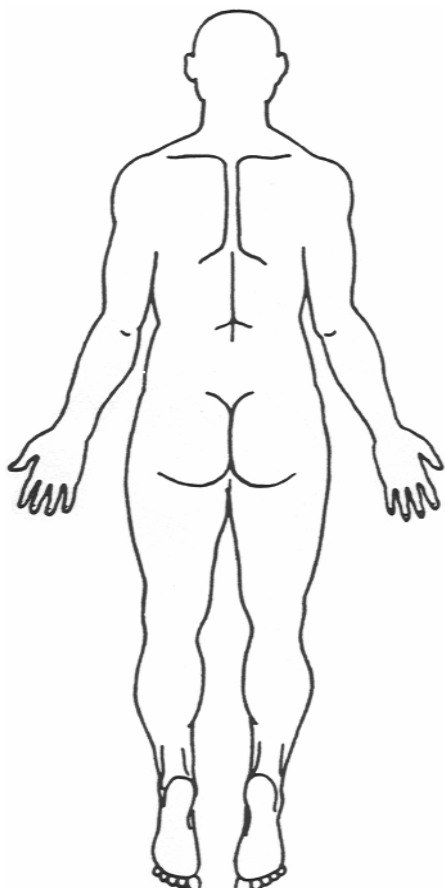
DESCRIBE YOUR SYMPTOMS

Name _____

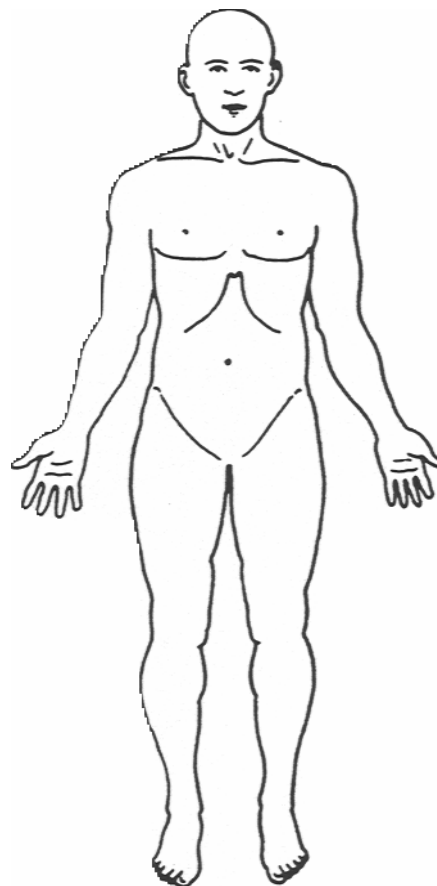
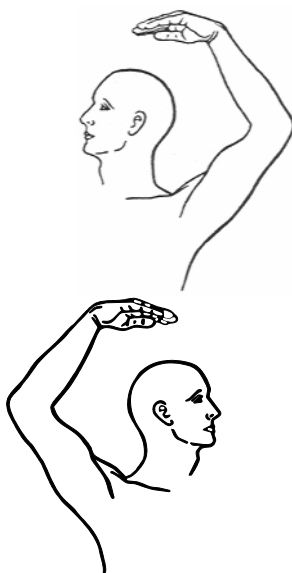
#

Date _____

Please indicate the appropriate location of pain and the symbol that best describes the discomfort you are presently experiencing.



Sharp and Stabbing = + + + +
 Dull and Achy = V V V V
 Pins and Needles = 0 0 0 0
 Numbness = / / / / / / / /



Rate your activity level:	<u>Low</u>	<u>Moderate</u>	<u>High</u>
Work Activity	Low 1 2 3 4 5		High
Pleasure Activity	Low 1 2 3 4 5		High

Check # below to rate your current pain level
 #1 being almost pain free - #10 being Severe

C = Constant
I = Intermittent

Area of Pain	Normal		Mild			Moderate			Severe			C	I
Neck	0	1	2	3	4	5	6	7	8	9	10	C	I
Middle Back	0	1	2	3	4	5	6	7	8	9	10	C	I
Lower Back	0	1	2	3	4	5	6	7	8	9	10	C	I
Hip(s)	0	1	2	3	4	5	6	7	8	9	10	C	I
Shoulder(s) Lft Rt	0	1	2	3	4	5	6	7	8	9	10	C	I
Arm(s) Lft Rt	0	1	2	3	4	5	6	7	8	9	10	C	I
Leg(s) Lft Rt	0	1	2	3	4	5	6	7	8	9	10	C	I
Headaches	0	1	2	3	4	5	6	7	8	9	10	C	I
Other:	0	1	2	3	4	5	6	7	8	9	10	C	I
Other:	0	1	2	3	4	5	6	7	8	9	10	C	I