

Motor Vehicle Accident

PERSONAL INJURY QUESTIONNAIRE

INFORMATION ABOUT YOU...

Name: _____ Home Phone: () _____ Cell Phone: () _____
Address: _____ City: _____ State: _____ Zip: _____
Age: _____ Birth Date: _____ Sex: **M or F** S/S#: _____ - _____ DL# _____
E-mail: _____ Occupation: _____ Work Phone: () _____
Employer's Name: _____ Employer's Address: _____

INFORMATION ABOUT YOUR ATTORNEY...

Name: _____ Office Phone: () _____ Office Fax: () _____
Address: _____ City: _____ State: _____ Zip: _____
Were there any witnesses? **Yes or No** Names: _____

INFORMATION ABOUT YOUR ACCIDENT...

1. Date of Accident: _____ Time of Day: _____ **a.m. / p.m.** (circle)
2. Were you the: **Driver** **Front Seat Passenger** **Back Seat Passenger** *L R C* **3rd Row Seat Passenger** *L R C*
3. Number of people in your vehicle other than yourself? _____ Were you wearing seat belts? **Yes or No**
4. What direction were you headed? North South East West
on: _____
5. What direction was the other vehicle headed? North South East West
on: _____
6. Were you struck from: **Front** **Behind** **Left Side** **Right Side**
7. Approximate speed of your car: _____ mph. Other car: _____ mph. (**your best estimation of speed**)
8. Were you knocked unconscious? **Yes** **No** If yes, for how long? _____
9. Were the police notified? **Yes** **No** If yes, was a report taken? **Yes** **No** **Your Case #:** _____
10. In your own words, please describe the accident: _____

11. Did you have any physical complaints **BEFORE THE ACCIDENT?** **Yes** **No**
If yes, describe: _____
12. Please describe how you felt: (e.g. "I had a dull ache at the back of my neck")
 - a. **DURING** the accident: _____
 - b. **IMMEDIATELY AFTER** the accident: _____
 - c. **LATER THAT DAY:** _____
 - d. **THE NEXT DAY:** _____

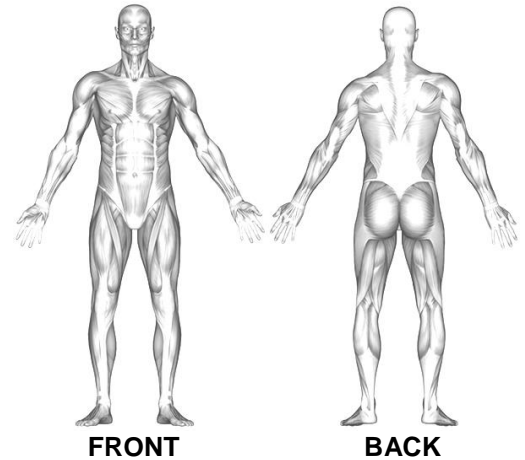
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13. What are your **PRESENT** complaints and symptoms?
(What Hurts the Worst Since Your Accident is #1)

1. _____
2. _____
3. _____
4. _____

PLACE AN "X" WHERE YOU HAVE PAIN



14. Do you have any congenital (from birth) factors which relate to this problem? Yes No
If yes, please explain: _____

15. Do you have any previous illnesses which relate to this case?
 Yes No If yes, please explain... _____

16. Have you ever been involved in an accident before? Yes No

If yes, please describe, including dates and types of accident as well as injuries received:

17. Regarding your current accident, where were you taken after the accident? _____

18. Have you been treated by another doctor since the accident? Yes No
If yes, by whom... _____

19. Since the injury occurred, are your symptoms: Improving Getting Worse Same

20. CHECK SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT:

- | | | | | |
|--|--|--|--------------------------------------|--|
| <input type="checkbox"/> HEADACHE | <input type="checkbox"/> MID-BACK PAIN | <input type="checkbox"/> IRRITABILITY | <input type="checkbox"/> DIZZINESS | <input type="checkbox"/> BUZZING IN EARS |
| <input type="checkbox"/> NECK PAIN | <input type="checkbox"/> LOW BACK PAIN | <input type="checkbox"/> FATIGUE | <input type="checkbox"/> EAR RING | <input type="checkbox"/> SLEEP PROBLEMS |
| <input type="checkbox"/> NECK STIFFNESS | <input type="checkbox"/> GLUTEAL PAIN | <input type="checkbox"/> FAINTING | <input type="checkbox"/> MEMORY LOSS | <input type="checkbox"/> STOMACH UPSET |
| <input type="checkbox"/> NUMBNESS- FINGERS | <input type="checkbox"/> SHOULDER PAIN | <input type="checkbox"/> LOSS OF SMELL | <input type="checkbox"/> COLD HANDS | <input type="checkbox"/> NERVOUSNESS |
| <input type="checkbox"/> NUMBNESS- TOES | <input type="checkbox"/> CONSTIPATION | <input type="checkbox"/> LOSS OF TASTE | <input type="checkbox"/> COLD FEET | <input type="checkbox"/> BALANCE LOSS |
| <input type="checkbox"/> NUMBNESS- ARMS | <input type="checkbox"/> COLD SWEATS | <input type="checkbox"/> DEPRESSION | <input type="checkbox"/> DIARRHEA | <input type="checkbox"/> FEVER |
| <input type="checkbox"/> NUMBNESS- LEGS | <input type="checkbox"/> CHEST PAIN | <input type="checkbox"/> FACE FLUSHED | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |

Symptoms other than above: _____

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

Last day worked: _____ Type of employment: _____

Present salary: _____ Are you being compensated for time lost from work? Yes No

If yes, what type of compensation you are receiving: _____

22. Do you notice any activity restrictions as a result of this injury? Yes No
If yes, please explain: _____

23. Other pertinent information: _____

I certify that the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through my provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future.

Patient Signature: _____ Date: _____