Personal Injury Questionnaire

Name____

Have you retained an attorney? ☐Yes ☐No. If yes, name_________________________________

Were there any witnesses? ☐Yes ☐No. If yes, name(s)_______________________________

Is your auto insurance: ☐Verbal threshold ☐No threshold applies

Nature of Accident: *(Skip questions 2-13 if accident is non-auto related).*

1. Date of Accident_________________Time of day___________ City/State ____________________________
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 other vehicle headed? ☐North ☐East ☐South ☐West
6. Were you struck from: ☐Behind ☐Front ☐Left side ☐Right side
   List any parts of your body that made contact with vehicle parts:_______________________________
7. Were you knocked unconscious? ☐Yes ☐No. If yes, for how long?____________________
8. If vehicle had head rest, describe the position compared to your head.
   ☐Top of headrest aligned with top of head.
   ☐Top of headrest aligned with middle of head.
   ☐Top of headrest aligned with bottom of head.
9. Were you braced for impact? ☐Yes ☐No
10. Were brakes applied? ☐Yes ☐No
11. Were you looking up into the: ☐inside rear view mirror ☐Outside door mirror
12. Was your car stopped? ☐Yes ☐No
13. Estimated speed of your vehicle:_____________________ Other vehicle:_____________________
14. Were police notified? ☐Yes ☐No
15. In your own words, please describe accident:____
____
____
____
16. Did you have any physical complaints **before the accident**? ☐Yes ☐No
17. Please describe how you felt:
    a. During the accident:____
    b. Immediately after the accident:____
    c. Later that day:____
    d. The next day:____
18. What are your present complaints and symptoms?____
____
____
19. Do you have any congenital, (from birth), factors which relate to this problem? ☐Yes ☐No. If yes, please describe:____
20. Do you have any previous illnesses which relate to this case? ☐Yes ☐No. If yes, please describe:_____
____
21. Have you ever been in involved in an accident before? ☐Yes ☐No. If yes, please describe, including dates and type of accident, as well as injuries received:____
____
22. Did you go to the hospital? ☐Yes ☐No. If yes, hospital name____________________________
    If yes, did you go by: ☐ambulance ☐other____
    If admitted to hospital, how long did you stay?____
    Please check and describe all that apply: ☐X-rays____

(Hospital information, continued)

Medication________________________________ Collar/brace______________________________________

Treatment__________________________________ Recommendations____________________________

23. Have you been treated by another doctor since the accident? ☐Yes ☐No. If yes, please list the doctor's name and address:____

If no, please enter your regular family doctor:____

24. Since this injury occurred, are your symptoms: ☐Improving ☐Getting worse ☐Same

25. Have you lost time from work as a result of this accident? ☐Yes ☐No. If so, How long?__________

26. Do you notice any activity restrictions as a result of this injury? ☐Yes ☐No. If yes, please describe, **in detail:**____

Present complaints

☐Headache	☐Neck Pain	☐Chest Pain	☐Nausea
☐Concentration loss	☐Neck stiffness	☐Shortness of breath	☐Diarrhea
☐Sensitivity to light	☐Neck Motion Restricted	☐Irritable	☐Vomiting
☐Memory loss	☐Upper Back Pain/Stiff	☐Numbness, (______)	☐Swelling, (__________________)
☐Heavy feeling of head	☐Mid Back Pain/Stiff	☐Anxiety	☐Cold Hands
☐Dizziness	☐Low Back Pain/Stiff	☐Depression	☐Cold Feet
☐Ringing in Ears	☐Right/Left Shoulder Pain	☐Insomnia	☐Loss of Consciousness
☐Loss of balance	☐Right/Left Arm Pain	☐Fatigue	☐Cuts, (______________________)
☐Loss of smell	☐Low Back Pain	☐Flushed Face	☐Bleeding, (___________________)
☐Loss of taste	☐Right/Left Leg Pain	☐Pale Face	☐Broken Bones, (_______________)
☐Pain behind eyes	☐Pins & Needles arms/legs	☐Excess Perspiration	☐Bruises
☐Intolerance to alcohol	☐Vision Problems	☐Neuritis	☐Jaw Pain
☐Fainting	☐Sinus Trouble	☐Constipation	☐Other, (_____________________)
☐Palpitation	☐Nervousness	☐Digestive Trouble	☐Other, (_____________________)

Aggravation of Pain Upon: ☐Walking ☐Sitting ☐Standing ☐Bending ☐Riding

General Health History

☐Cancer	☐Epilepsy	☐Digestive Problems
☐Tuberculosis	☐Dizziness	☐Numbness
☐Hypertension	☐Convulsions	☐Tingling
☐Diabetes	☐Concussion	☐Anemia
☐Arthritis	☐Allergies	☐Back Problems
☐Migraine	☐Heart Attack	☐Rheumatic/Scarlet Fever
☐Sinus History	☐Polio	☐Venereal Disease
☐Asthma	☐Multiple Sclerosis	☐Neuritis
☐Hepatitis	☐Muscular Dystrophy	☐Rheumatism
		☐Psoriasis

If you are female, are you pregnant? ☐Yes, How long:__________ ☐No, Last menstrual period______________

Any prior hospitalization or surgery? ☐Yes ☐No. If yes, list:____

______________________________ ____

Date Signature