

PERSONAL INJURY QUESTIONNAIRE

NAME: _____ Date of Accident _____

Where did accident happen (Location) ? Describe the accident in your own words: Time of Accident _____

Weather conditions at the time of the accident, ex: dry, bright, sunny, wet, fog _____

Are you left or right handed? _____

How many passengers were in the car? _____

Driver: if Driver were your hands on the steering wheel? Left Right Both

Passenger: If passenger, were you sitting in Front Right Rear Left Rear

Did your vehicle strike another vehicle Yes No

Was your vehicle struck by another vehicle Yes No

Your vehicle: Year _____ Make _____ Model _____ Your Speed _____

Other vehicle: Year _____ Make _____ Model _____ Their Speed _____

What direction was your car headed West East South North

What direction was the other car headed West East South North

Angles of impact... First Collision: Front Back Left Right

If Second Collision: Front Back Left Right

Accident Type Rear Ended Head On Broad Sided

Damage to your car: _____

Damage to other car: _____

Were you wearing a seat belt? Yes No

Were you under the influence of drugs or alcohol? Yes No

Females: Were you pregnant at time of accident? Yes No

Did you see collision coming Yes No

If yes, did you..... step on the brake let off the brake other

If other, please explain

Did you brace for impact? Yes No ... I braced with my hands I braced with my feet

Which way were you facing at the time of impact... Straight Ahead Left Right

What position were your vehicle head rests in? lowest middle highest

What position was your body in just prior to the impact? straight rotated left rotated right can't remember

Did you strike anything in vehicle at time of impact? Yes No

If yes, specify what part of your body struck what: ie... head chest chin shoulder Right / Left Knee

Steering Wheel _____ Dashboard _____

Windshield _____ Roof _____

Left Side Door _____ Right Side Door _____

Left Side Window. _____ Right Window _____

Other _____

Did the seat back bend / break ? Yes No

Immediately following the accident, how did you feel? dizzy/dazed disoriented unconscious

nervous nauseous upset weak Other _____

Symptoms immediately following the accident: (ex: any pains, blurry vision, motor loss, paresthesia)

Symptoms later that day: (ex: neck pain, shoulder pain, blurry vision, motor loss, paresthesia)

Symptoms the day after the accident: (ex: any pain, headache, insomnia, inability to concentrate, motor loss, paresthesia)

Were police called to the scene of the accident? Yes No

If so, do you have a copy of the police report? Yes No

Did you go to hospital Yes No Were you admitted to the hospital? Yes No if yes how long? _____

If you went to hospital, when? At time of accident Next day

How did you get to hospital? Ambulance Police Car Private Transportation

Name of Hospital: _____

Attended by Dr. _____

... what treatment was given?

none placed in a cervical collar x-rayed given stitches Bandaged

given pain medication given instructions regarding concussions

given instructions regarding sprains and strains Physical Therapy

instructed to call a Orthopedic Surgeon instructed to call a private physician

referred to this office for treatment Other _____

....what were your diagnosed injuries?

Have you seen any other doctor as a result of this accident? Yes No

For what? _____

Doctor's name

Current CHIEF Complaints or Symptoms:

Name:

Date:

<input type="checkbox"/> Neck pain check off the areas that the pain runs into from the neck	<input type="checkbox"/> none <input type="checkbox"/> left shoulder <input type="checkbox"/> left arm <input type="checkbox"/> left forearm <input type="checkbox"/> left hand <input type="checkbox"/> right shoulder <input type="checkbox"/> right arm <input type="checkbox"/> right forearm <input type="checkbox"/> right hand
<input type="checkbox"/> headache	
<input type="checkbox"/> Migraine Headache	
<input type="checkbox"/> upper back pain	

Ringing in Ears Yes No Left Right Both Ears
Blurry Vision Yes No Left Right Both Eyes
Wrist Pain Yes No Left Right Both Wrists

Jaw Pain Yes No Left Right Both Sides

dizziness nervousness fatigue anxiety depression excessive irritability
fear of driving in a car a loss of concentration jaw clenching grinding of teeth at night
nightmares difficulty with sleeping at night

<input type="checkbox"/> Low Back Pain select the areas of radiation, if any...	<input type="checkbox"/> none <input type="checkbox"/> buttocks <input type="checkbox"/> left buttock <input type="checkbox"/> left thigh <input type="checkbox"/> left knee <input type="checkbox"/> left foot <input type="checkbox"/> right buttock <input type="checkbox"/> right thigh <input type="checkbox"/> right knee <input type="checkbox"/> right foot
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Hip Pain	<input type="checkbox"/> Left	<input type="checkbox"/> Right	<input type="checkbox"/> Bilateral
Knee Pain	<input type="checkbox"/> Left	<input type="checkbox"/> Right	<input type="checkbox"/> Bilateral
Foot Pain	<input type="checkbox"/> Left	<input type="checkbox"/> Right	<input type="checkbox"/> Bilateral

Numbness:

Left Hand Left Upper Arm Right Hand Right Upper Arm
 Left Foot Left Leg Right Foot Right Leg

Additional Symptoms/ Complaints:

Have you lost any time from work due to your injuries? Yes No

If yes please give dates: _____

Type of employment at time of accident: _____

Current type of employment: _____

Have you had previous injuries or accidents? Yes No

Description of previous Accident: _____

Description of previous injuries: _____

Is there any residual pain from the previous injury? Yes No

How much better did you feel prior to your current condition? (Example 100%, 80% etc.) _____

How would you describe your health prior to the accident? (Example, excellent, good, poor) _____

What types of exercise were you able to perform prior to the accident and how often? _____

What types of activities were you able to do prior to the accident that you are unable to do now?

(inc.activities of daily living) _____

Do you have any pre-existing conditions that were aggravated by the accident? _____

INSURANCE/ATTORNEY INFORMATION:

Your Insurance Company: _____ Name of Agent: _____
Ins. Co. Address: _____ City _____ St _____ Zip _____
Ins.Co. Phone: _____ Agent's Phone: _____
Claim Number _____

Other party Insurance Company: _____ Name of Agent: _____
Ins. Co. Address: _____ City _____ St _____ Zip _____
Ins.Co. Phone: _____ Agent's Phone: _____
Claim Number _____

Have you retained an Attorney? Yes No

Your Attorney's Name: _____ Phone # _____

Attorney's Address: _____

Were there any Witnesses? Yes No Name(s) _____