PERSONAL INJURY QUESTIONAIRE

Name ____

If you have an attorney please provide us with the following Name ____________________

Address ____ Phone # __________

Were there any witnesses? __Yes __No Name(s) ____________________________

NATURE OF ACCIDENT:

1. Date of Accident: ________ Time of Day: ________ Weather Conditions____________
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? (Street) __________
5. Direction of other vehicle? __ North __ East __ South __ West On? (Street) __________
6. Where were you struck? __ Behind __ Front __ Left Side __ Right Side
7. Did your airbags deploy? __Yes __No
8. Who was called to the accident? ____
9. Was a police report done? __ Yes __ No
10. What was the total damage to your car? (If known) ______________________________
11. Were you rendered unconscious? _ Yes _ No If yes, for how long? ________________
12. Any: _____ Fractures _______ Cuts _______ Abrasions _____ Bruises _____ Burns
13. Please describe how you felt:

a. **DURING** the accident: ____

b. **IMMEDIATELY AFTER** the accident: ______________________________________

c. **LATER THAT DAY**: ____

d. **THE NEXT DAY**: ____

14. Were you taken to the Emergency Room? __Yes __No

If yes, how were you transported there?____

15. Were you admitted to the hospital? If yes please provide us with the hospital name: __________

16. What did you do right after the accident? (ex. Go home, go to work, etc) ________________

17. In your own words, please describe the accident: ____________________________

____

18. What are your **PRESENT** complaints and symptoms? ________________________

____

19. Have you been treated by another doctor since the accident? __ Yes __ No

If yes, please list doctor's name and address: ____________________________

What type of treatment did you receive? ____

____

20. Since this injury occurred, are your symptoms: __ Improving __ Getting Worse __ Same

21. Have you lost time from work due to this accident? __ Yes __ No

If yes, please complete the following questions.

a. Last Day Worked: ____

b. Type of Employment: ____

c. Are you being compensated for time lost from work? __ Yes __ No If yes, please state type of compensation you are receiving: ____

22. Do you notice any activity restrictions due to this injury? __ Yes __ No If yes, please describe in detail: ____

23. Other pertinent information: ____

____

24. Did you have any physical complaints **BEFORE THE ACCIDENT?** __ Yes __ No

If yes, please describe in detail:____

____

25. Do you have any congenital (from birth) factors which relate to this problem? __Yes __No

If yes, please describe:____

26. Do you have any previous illnesses which relate to this case? __Yes __No

If yes, please describe: ____

27. Have you ever been involved in an auto accident or slip and fall prior to this accident? __Yes __No

If yes, please describe, including date(s), and type(s) of accidents, as well as injuries received. __________

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_______________________________ _______________________________

Date Patient's Signature