PERSONAL INJURY QUESTIONNAIRE

Patient's Name: ____ Date: ______________________

Address: ______________________________________ City: __________________State: ______Zip: ________

Age: _________ D.O.B: _________________ Sex: ________ S/S#: _____________________________

Home Phone: ______________________ Cell Phone: _____________________ Work Phone:_______________

Email address: _____________________________________ May we contact you via e-mail? Y ___ N ___

Employer's Name: __________________________ Address: ____

Your Insurance Company: ___________________________________ Adjuster: __________________________

Claim Number: _________________________________ Policy No: ____________________________________

Name on Policy (if other than self): ____

Date of Accident: _________________________________ Time of Accident: _______________ AM/PM

Have you contacted an insurance adjuster or representative regarding this claim? ☐ Yes ☐ No

Have you engaged services of an attorney? ☐ Yes ☐ No

Attorney: ____________________________________

Address: _____________________________________ City: ____________________ State: ______ Zip: _______

Phone: ______________________________________

Have you filed an accident/injury report? ☐ Yes ☐ No Have you filed for insurance benefits? ☐ Yes ☐ No

THE FOLLOWING QUESTIONS PERTAIN TO YOU AND THE VEHICLE YOU WERE IN:

Vehicle type:	**Vehicle size:**	**Your position in the vehicle:**
☐ Car ☐ Station Wagon ☐ Van ☐ Pickup Truck ☐ Bus ☐ Large Truck ☐ Other _______________	☐ Subcompact ☐ Full-Size ☐ Compact ☐ Mini ☐ Mid-size ☐ Light ☐ Heavy ☐ Other ____________	☐ Driver ☐ Front Passenger ☐ Left Rear Passenger ☐ Right Rear Passenger ☐ Other _____________________

Speed of your vehicle:	**What was your vehicle doing at the time of the accident?**
☐ Stopped ☐ Moving Moderately ☐ Parked ☐ Moving Fast ☐ Slowing ☐ Moving at approx ___MPH ☐ Moving Slowly	☐ Stopped in traffic ☐ Stopped at light ☐ Proceeding along ☐ Stopped at intersection ☐ Parking ☐ Other ________ ☐ Making a right turn ☐ Accelerating _______________ ☐ Making a left turn ☐ Slowing down _______________

Collision Type: ☐ Driver Side Impact ☐ Passenger Side Impact ☐ Front Impact ☐ Head On Collision ☐ Rear Impact ☐ Pedestrian Incident

THE FOLLOWING QUESTIONS CONCERN THE OTHER VEHICLE INVOLVED IN THE ACCIDENT:

Vehicle type:	**Vehicle size:**
☐ Car ☐ Station Wagon ☐ Van ☐ Pickup Truck ☐ Bus ☐ Large Truck ☐ Other ________________	☐ Subcompact ☐ Full-Size ☐ Compact ☐ Mini ☐ Mid-size ☐ Light ☐ Heavy ☐ Other ____________

PLEASE DESCRIBE IN YOUR OWN WORDS WHAT HAPPENED:

CONDITIONS AT THE TIME OF THE ACCIDENT:

Time of day:	Road Conditions:	Visibility:	If visibility was poor, why?
☐ Daylight ☐ Dawn ☐ Dusk ☐ Other _______	☐ Dry ☐ Damp ☐ Wet ☐ Snow Covered ☐ Icy ☐ Other _____________	☐ Excellent ☐ Good ☐ Fair ☐ Poor	☐ Brightness ☐ Snow ☐ Darkness ☐ Fog ☐ Rain ☐ Traffic ☐ Snow ☐ Other ______________

THE FOLLOWING QUESTIONS CONCERN THE MOMENT OF THE IMPACT OF THE ACCIDENT:

Were you:
- ☐ Totally unaware that the accident was impending
- ☐ Aware that the accident was impending
- ☐ Aware that the accident was impending and braced for impact

Was your foot on the brake pedal?
- ☐ Yes
- ☐ No
- ☐ Knocked off by impact

Restraints:
- ☐ Seat belt
- ☐ Shoulder harness
- ☐ No restraints

Was the air bag deployed?
- ☐ Car not equipped with air bags
- ☐ Air bag deployed
- ☐ Air bag did not deploy

What position was YOUR headrest in?
- ☐ High position ☐ Unsure
- ☐ Middle position
- ☐ Low position

Position of your BODY at time of impact?
- ☐ Facing straight ahead
- ☐ Tilted forward
- ☐ Rotated to the left
- ☐ Rotated to the right

Was your BODY thrown...?
- ☐ Backward and then forward
- ☐ Forward then backward
- ☐ To the left ☐ To the left, then the right
- ☐ To the right ☐ To the right, then the left
- ☐ Across vehicle ☐ Outside vehicle
- ☐ Under vehicle ☐ Don't recall

Position of your HEAD at time of impact?
- ☐ Facing straight ahead
- ☐ Tilted forward
- ☐ Rotated to the left
- ☐ Rotated to the right

Was your HEAD thrown?
- ☐ Backward and then forward
- ☐ Forward then backward
- ☐ To the left ☐ To the left, then the right
- ☐ To the right ☐ To the right, then the left

Damage to vehicle YOU were in:
- ☐ Minimal damage
- ☐ Moderate damage
- ☐ Severe damage
- ☐ Totaled
- ☐ Not known

Were Citations issued?
- ☐ None issued
- ☐ Yourself
- ☐ Driver of vehicle you were in
- ☐ Driver of other vehicle
- ☐ Not sure

AS A RESULT OF THE FORCE OF THE COLLISION, WHICH OBJECTS IN THE VEHICLE DID YOUR BODY STRIKE?

Head:	Left Arm:	Right Arm:	Torso:
☐ Steering wheel	☐ Steering wheel	☐ Steering wheel	☐ Steering wheel
☐ Dashboard	☐ Dashboard	☐ Dashboard	☐ Dashboard
☐ Windshield	☐ Windshield	☐ Windshield	☐ Windshield
☐ Armrest	☐ Armrest	☐ Armrest	☐ Armrest
☐ Headrest	☐ Headrest	☐ Headrest	☐ Headrest
☐ Rear view mirror	☐ Rear view mirror	☐ Rear view mirror	☐ Rear view mirror
☐ Left door	☐ Left door	☐ Left door	☐ Left door
☐ Right door	☐ Right door	☐ Right door	☐ Right door
☐ Left window	☐ Left window	☐ Left window	☐ Left window
☐ Right window	☐ Right window	☐ Right window	☐ Right window
☐ Console	☐ Console	☐ Console	☐ Console
☐ Gear shift	☐ Gear shift	☐ Gear shift	☐ Gear shift
☐ Front seat	☐ Front seat	☐ Front seat	☐ Front seat
☐ Backseat	☐ Backseat	☐ Backseat	☐ Backseat
☐ Ceiling	☐ Ceiling	☐ Ceiling	☐ Other ____________
☐ Other ____________	☐ Other ____________	☐ Other ____________	

Left Leg:		Right Leg:	
☐ Steering wheel	☐ Left window	☐ Steering wheel	☐ Left window
☐ Dashboard	☐ Right window	☐ Dashboard	☐ Right window
☐ Windshield	☐ Console	☐ Windshield	☐ Console
☐ Armrest	☐ Gear shift	☐ Armrest	☐ Gear shift
☐ Headrest	☐ Front seat	☐ Headrest	☐ Front seat
☐ Rear view mirror	☐ Backseat	☐ Rear view mirror	☐ Backseat
☐ Left door	☐ Other ___________	☐ Left door	☐ Other ___________
☐ Right door		☐ Right door	

THE FOLLOWING QUESTIONS CONCERN THE TIME PERIOD IMMEDIATELY FOLLOWING THE ACCIDENT:

Did you lose consciousness?
☐ Yes
☐ No
☐ Don't Know

Immediately following the accident, how did you feel?
☐ Confused ☐ Disoriented ☐ Angry
☐ Dizzy ☐ Weak ☐ Shocked
☐ Dazed ☐ Nervous
☐ Nauseated ☐ Other ___________

Were you able to walk unaided?
☐ Yes
☐ No

Where did you go?
☐ Hospital
☐ School
☐ Home
☐ Work
☐ Other ___________

By whom were you driven?
☐ Myself
☐ Friend
☐ Ambulance
☐ Family member
Other ___________

Next day discomfort?
☐ Increased
☐ Decreased
☐ Same

Did your major complaints exist before the accident?
☐ Yes
☐ No

In what areas did you IMMEDIATELY feel pain?

☐ Head	☐ L	☐ R	Shoulder
☐ Neck	☐ L	☐ R	Arm
☐ Upper Back	☐ L	☐ R	Elbow
☐ Mid Back	☐ L	☐ R	Wrist
☐ Ribs	☐ L	☐ R	Hand
☐ Chest	☐ L	☐ R	Fingers
☐ Abdomen	☐ L	☐ R	Buttock
☐ Low Back	☐ L	☐ R	Hip
☐ Pelvis	☐ L	☐ R	Thigh
	☐ L	☐ R	Knee
	☐ L	☐ R	Calf
	☐ L	☐ R	Ankle
	☐ L	☐ R	Foot
	☐ L	☐ R	Toes

If there were lacerations (cuts), where were they?

☐ Head	☐ L	☐ R	Shoulder
☐ Neck	☐ L	☐ R	Arm
☐ Upper Back	☐ L	☐ R	Elbow
☐ Mid Back	☐ L	☐ R	Wrist
☐ Ribs	☐ L	☐ R	Hand
☐ Chest	☐ L	☐ R	Fingers
☐ Abdomen	☐ L	☐ R	Buttock
☐ Low Back	☐ L	☐ R	Hip
☐ Pelvis	☐ L	☐ R	Thigh
	☐ L	☐ R	Knee
	☐ L	☐ R	Calf
	☐ L	☐ R	Ankle
	☐ L	☐ R	Foot
	☐ L	☐ R	Toes

Did you receive emergency care?
☐ Yes ☐ No

What type of emergency care did you receive?
☐ Bandages
☐ Splints
☐ Brace
☐ Neck collar
☐ Other _________

When did you go to the hospital?
☐ Immediately
☐ Later that day
☐ Next day
☐ Days later
☐ Date _________
☐ Other _________

Hospital Name ________________________

Examined by Dr. _______________________

Admitted? ☐ Yes ☐ No

Date discharged ___________

What treatment was performed? ____________________________________

What diagnosis was given? ____

Have you been for consultation/treatment anywhere else? Y / N

Facility Name: ____________________________**Dr. Name:**________________

What treatment was performed? ____________________________________

What diagnosis was given? ____

At the hospital, what areas were x-rayed?

- ☐ Head
- ☐ Neck
- ☐ Upper Back
- ☐ Mid Back
- ☐ Ribs
- ☐ Chest
- ☐ Abdomen
- ☐ Low Back
- ☐ Pelvis

- ☐ L ☐ R Shoulder
- ☐ L ☐ R Arm
- ☐ L ☐ R Elbow
- ☐ L ☐ R Wrist
- ☐ L ☐ R Hand
- ☐ L ☐ R Fingers
- ☐ L ☐ R Buttock
- ☐ L ☐ R Hip
- ☐ L ☐ R Thigh
- ☐ L ☐ R Knee
- ☐ L ☐ R Calf
- ☐ L ☐ R Ankle
- ☐ L ☐ R Foot
- ☐ L ☐ R Toes

What treatment was administered at the hospital?

- ☐ Oral medication
- ☐ Injection
- ☐ Topical antiseptics
- ☐ Bandages
- ☐ Sutures
- ☐ Ice packs
- ☐ Hot packs
- ☐ Splint
- ☐ Cast
- ☐ Brace
- ☐ Collar
- ☐ Support
- ☐ Surgery
- ☐ Other________ ____________

Instructions given when discharged from hospital:
Who were you told to see?

- ☐ General Practitioner
- ☐ Chiropractor
- ☐ Physical Therapist
- ☐ Plastic Surgeon
- ☐ Other _______________
- ☐ General Surgeon
- ☐ Orthopedist
- ☐ Neurologist
- ☐ Internist

What recommendations were made?

- ☐ No Further Care
- ☐ No Follow Up Instructions
- ☐ Observation
- ☐ Rest
- ☐ Ice
- ☐ Heat
- ☐ Collar
- ☐ Support
- ☐ Time Off Work
- ☐ Other ______

Were medications prescribed?

- ☐ Pain
- ☐ Anti-Inflammatory
- ☐ Antibiotic
- ☐ Other _______________

How much later did additional symptoms develop?

- ☐ Immediately
- ☐ Hours
- ☐ That Evening
- ☐ Next Morning
- ☐ Days
- ☐ Week
- ☐ Month
- ☐ Other ____________

What additional symptoms developed? Please describe:

Since your accident/injury have you suffered from?

- ☐ Blurred Vision
- ☐ Double Vision
- ☐ Reduced Vision
- ☐ Impaired Hearing
- ☐ Ringing in Ears
- ☐ Chest Pain
- ☐ Difficulty Breathing
- ☐ Palpitations
- ☐ Constipation
- ☐ Diarrhea
- ☐ Nausea
- ☐ Vomiting
- ☐ Frequent Urination
- ☐ Inability to Hold Urine
- ☐ Painful Urination

Additionally, have you experienced any of the following?

- ☐ Anxiety
- ☐ Depression
- ☐ Mood Swings
- ☐ Nervousness
- ☐ Poor Memory
- ☐ Tension
- ☐ Convulsions
- ☐ Dizziness
- ☐ Headaches
- ☐ Fainting
- ☐ Loss of Balance
- ☐ Fatigue
- ☐ Restlessness
- ☐ Insomnia
- ☐ Light Sensitivity
- ☐ Reduced Appetite
- ☐ Weakness
- ☐ Weight Gain
- ☐ Weight Loss
- ☐ Other __________________

Are you restricted in any of the following areas as a result of this accident/injury?

- ☐ Daily Living
- ☐ Occupation/Work
- ☐ Recreational Activities
- ☐ Other _________________

Did you seek medical care elsewhere? If so, who did you see and what care did you receive?

Dr. _______________________

Type of Physician: ____________________

Diagnosis and Treatment:

____

Patient's or Guardian Signature: ____ Date: ___________________