PERSONAL INJURY QUESTIONNAIRE

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NAME _____ DATE OF BIRTH _____

MARITAL STATUS (CIRCLE ONE) M S D W SOCIAL SECURITY _____-____-_____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME TELEPHONE _____ WORK TELEPHONE _____

CELULAR _____ FAX _____

BEEPER _____ EMAIL _____@_____

INSURANCE/ATTORNEY INFORMATION:

Your Auto Insurance Company and Address _____

Policy Number (Please give us your insurance card to copy) _____

Other Vehicle: Driver's Name _____ Insurance Company _____

Were you in the course of your employment? ( ) YES ( ) NO If Yes, please let us know ASAP!

Have you retained an attorney? _____ Name & Phone Number _____

Were there any witnesses? _____ Names & Phone Numbers _____

NATURE OF ACCIDENT:

1. Date of accident _____ Time of day _____
2. Were you ( ) Driver ( ) Passenger ( ) Front Seat ( ) Back Seat ( ) Wearing Seatbelt
3. Number of people in your vehicle _____ Other vehicle _____
4. What direction were you headed ( ) North ( ) South ( ) East ( ) West
5. What direction was the other vehicle headed ( ) North ( ) South ( ) East ( ) West
6. Were you struck ( ) Behind ( ) Front ( ) Left side ( ) Right side
7. Were you knocked unconscious? ( ) Yes ( ) No If yes, for how long? _____
8. Were police notified? ( ) Yes ( ) No If yes, please provide us with a copy of the report.
9. In your own words, please describe the accident: _____

   _____
10. Did you have any physical complaints BEFORE THE ACCIDENT ( ) yes ( ) no. If yes, please describe in detail:

    _____
11. Please describe how you felt:
    a. DURING the accident: _____
    b. IMMEDIATELY AFTER the accident: _____
    c. LATER THAT DAY: _____
    d. THE NEXT DAY: _____
12. What are your PRESENT complaints and symptoms? _____

    _____

13. a. Do you have any congenital (from birth) factors that relate to this problem? ( ) yes ( ) no. If yes, please describe:

_____

b. Do you have any previous illnesses that relate to this case? ( ) yes ( ) no. If yes, please describe: _____

_____.

c. Have you ever been involved in an accident before? ( ) yes ( ) no. If yes, please describe, including date(s) and types of accidents, as well as injury(ies) received: _____

_____

_____

14. Where were you taken after this accident? _____
15. Have you been treated by another doctor since this accident? ( ) yes ( ) no. If yes, please list doctor(s) name(s) and address(es): _____

a. What type of treatment did you receive? _____

16. Since this injury occurred, are your symptoms: ( ) improving ( ) getting worse ( ) same
17. CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT:

( ) Headache	( ) Irritability	( )Numbness in Toes	( ) Face Flushed	( ) Feet Cold
( ) Neck Pain	( ) Chest Pain	( ) Shortness of Breath	( ) Buzzing in Ears	( ) Hands Cold
( ) Neck Stiff	( ) Dizziness	( ) Stomach Upset	( ) Loss of Balance	( ) Fatigue
( ) Sleeping Problems	( ) Depression	( ) Head Seems Too Heavy	( ) Fainting	( ) Constipation
( ) Back Pain	( ) Light Bothers Eyes	( ) Pins & Needles in Arms	( ) Loss of Smell	( ) Cold Sweats
( ) Nervousness	( ) Loss of Memory	( ) Pins & Needles in Legs	( ) Loss of Taste	( ) Fever
( ) Tension	( ) Numbness in Fingers	( ) Ears Ring	( ) Diarrhea	( ) Other _____

Symptoms other then above _____

18. Have you lost time from work as a result of this accident? ( ) yes ( ) no. If yes, please complete this question:

a. Last Day Worked: _____

b. Type of Employment: _____ Occupation: _____

c. Present Salary: _____

d. Are you being compensated for time lost from work? ( ) yes ( ) no.

If yes, please state type of compensation you are receiving: _____

19. Do you notice any activity restrictions as a result of this injury? ( ) yes ( ) no. If yes, please describe in detail: _____

_____

20. Other pertinent information: _____

I understand and agree that health/accident policies are an arrangement between an insurance carrier and myself; all services rendered are charged directly to me and that I am personally responsible for payments. Additionally, I understand that I am responsible for notifying my insurance company about my accident and the timely filing of any required forms for this accident. If I fail to uphold my responsibilities regarding this accident, I understand that I will be liable in full for payment of services rendered.

Patient/Guardian's Signature _____ Date _____