

## PERSONAL INJURY QUESTIONNAIRE

NAME: \_\_\_\_\_ \*DOB \_\_\_\_\_ \*Date of Accident \_\_\_\_\_

Where did accident happen? Describe the accident in your own words:


\*What was your position 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

Was there an Accident Report Filed  Yes  No Did you bring a copy  Yes  No

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

If Second Collision:  Front  Back  Left  Right

\*Did the person who hit you run a  Stop Light  Stop Sign  Yield Sign  No Sign Involved?

\*Who had the right of way  the vehicle you were in  the other car  neither?

\*What was your approximate speed \_\_\_\_\_

\*What is the approximate damage to your car? \_\_\_\_\_ Approximate \$ \_\_\_\_\_

\*What is the approximate damage to the car that hit you? \_\_\_\_\_ Approximate \$ \_\_\_\_\_

Were you wearing a seat belt?  Yes  No

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

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 \_\_\_\_\_

\*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 \_\_\_\_\_

\_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

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

Doctor's name:

**\*CHIEF Complaints or Symptoms:**

<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:**


**\*Pain:**

<b>Describe the Pain if any...</b>	<input type="checkbox"/> none <input type="checkbox"/> Dull <input type="checkbox"/> sharp <input type="checkbox"/> burning <input type="checkbox"/> shooting <input type="checkbox"/> constant <input type="checkbox"/> intermittent
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\*When and what makes the pain worse? \_\_\_\_\_

\*When and what makes the pain better? \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

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

If yes please give dates: \_\_\_\_\_

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.) \_\_\_\_\_

\*List any operations you have previously had:

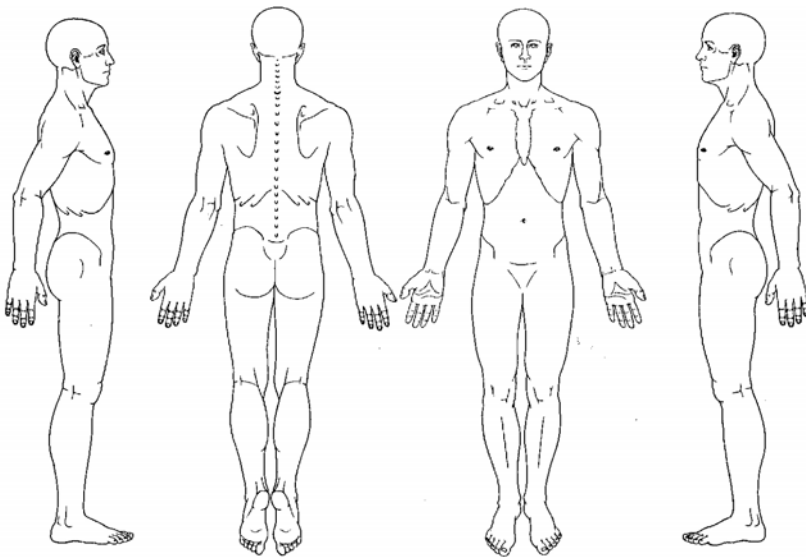

\*If female:

How many children \_\_\_\_\_ Natural C-Section      Ages of Children: \_\_\_\_\_ Male Female

\*Have you had any serious illness? \_\_\_\_\_

\*Has any one in your family had: Cancer Diabetes Heart Disease Other \_\_\_\_\_

**\*Please indicate with an "X" the area of complaint:**



**Patients Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**INSURANCE INFORMATION:**

**Insurance Responsible Party:**

Insured Name:	
Insurance Company:	
Company Address:	
Company Phone #:	Policy Number:

Do You Have Auto Insurance  Yes  No

Do You Have Med Pay Coverage  Yes  No Med Pay Limit \$ \_\_\_\_\_

Do You Have Uninsured Motorist Coverage  Yes  No UM Limit \$ \_\_\_\_\_

List Your Auto Insurance Company Information:

Company Name:	
Company Address:	
Company Phone Number:	Policy Number: