PERSONAL INJURY QUESTIONNAIRE

Name		Phone ()
Address	City	State	Zip
Age Birthdate	Sex	S/S#	
Employer's Name			
Your Ins. Co	_ Policy#	Agent's Name	
Name on Policy (If other than self)			
Responsible Party's Name			
Address			
Policy Holder's Name			
ATTORNEY			
Name		Phone ()
Address	City	State	Zip
Were there any witnesses? () Yes (
NATURE OF ACCIDENT:			80
1. Date of Accident	Time of Day		
2. Were you: () Driver () Pas	senger () Front Seat () Back	Seat	
3. Number of people in your vehicle?			
4. What direction were you headed?			
5. What direction was other vehicle hea			
	() 2401 (
6. Were you struck from: () Behind			
7. Approximate speed of your car		/ riight side	
8. Were you knocked unconscious?		nna?	
0 14/202 11/20 10/20 10/20	() No	,	
10. In your own words, please describe ac	ccident:		
11. Did you have any physical complaints	BEFORE THE ACCIDENT? () Yes	() No If yes, ple	ease describe in detail
12. Please describe how you felt:			
	t:		
			*

13. \	What are your PRESENT complaints and symptoms?
14.	Do you have any congenital (from birth) factors which relate to this problem? () Yes () No If yes, please describe:
15.	Do you have any previous illnesses which relate to this case? () Yes () No If yes, please describe:
	Have you ever been involved in an accident before? () Yes () No If yes, please describe, including date(s) and type(s) of accidents, as well as injury(ies) received.
	Where were you taken after the accident? 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?
19.	Since this injury occurred, are your symptoms: () Improving () Getting Worse () Same
20.	CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT: Headache
	Symptoms Other Than Above
21.	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:
	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:
22.	Do you notice any activity restrictions as a result of this injury? () Yes () No If yes, please describe, in details
23.	Other pertinent information:
	DATE PATIENT'S SIGNATURE