PERSONAL INJURY QUESTIONNAIRE

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Patient Information:

Patient Full Name: ____ Date:__________

Address:____

City: ______________________________ St.______ Zip: __________ Phone: ________________

Age: ____ Date of Birth:________________ Sex: M / F SSN#: ________________________

Spouses Name: ______________________________________ Date of Birth:____________

Employer: ______________________________________ Occupation: __________________

YOUR AUTO INSURANCE INFORMATION

Name of insured: __________________________________ Policy #: ____________________

Name of Ins. Co.:____________________________________ Phone:___________________

Address:____

City: ____ State:_________ Zip: __________

YOUR HEALTH INSURANCE INFORMATION

Name of insured: __________________________________ Policy #: ____________________

Ins. Co: ____ Phone: _____________________

Address:____

City: ______________________________________ St.:_________ Zip: ________________

AUTO INSURANCE OF THE OTHER PARTY INVOLVED

Name of Insured: ________________________________ Policy #:_____________________

Ins. Co.: _______________________________________ Phone:______________________

Address:____

City:____ St.:_________ Zip:________________

ATTORNEY INFORMATION (IF APPLICABLE)

Case #__________________________

Name: _____________________________________ Phone: ________________________

Address: ____

City: ______________________________________ St.: _________ Zip:________________

ACCIDENT INFORMATION:In your words,please describe the accident in detail:

____

____

____

____

____

____

Accident Date: _________Time of Day: _________ Night or Day: __________ Visibility: Poor / Good

Weather Conditions: Poor / Mild / Moderate / Severe Road Conditions: Safe / Unsafe

PERSONAL QUESTIONNAIRE

Were you: ( ) Driver ( ) Passenger ( ) Front Seat ( ) Back Seat ( ) Other: ________________

How many passengers were in the car with you? ______ Police Report: ( ) Yes / ( ) No

Please check the box for symptoms you have noticed SINCE the accident:

	Loss of Consciousness		Neck Pain
	Dizziness		Mid back pain
	Blurry Vision		Low back pain
	Headaches: How often: _____________		Bruising / Swelling
	Memory Loss: short term / Long Term		Stiffness
	Lightheadedness		Loss of Appetite
	Hearing Impairment / Ringing in ears		Difficulty Sleeping; Why:______________
	Fatigue		Inability to focus

Please list any other symptoms you are experiencing SINCE the accident: ______________________

____

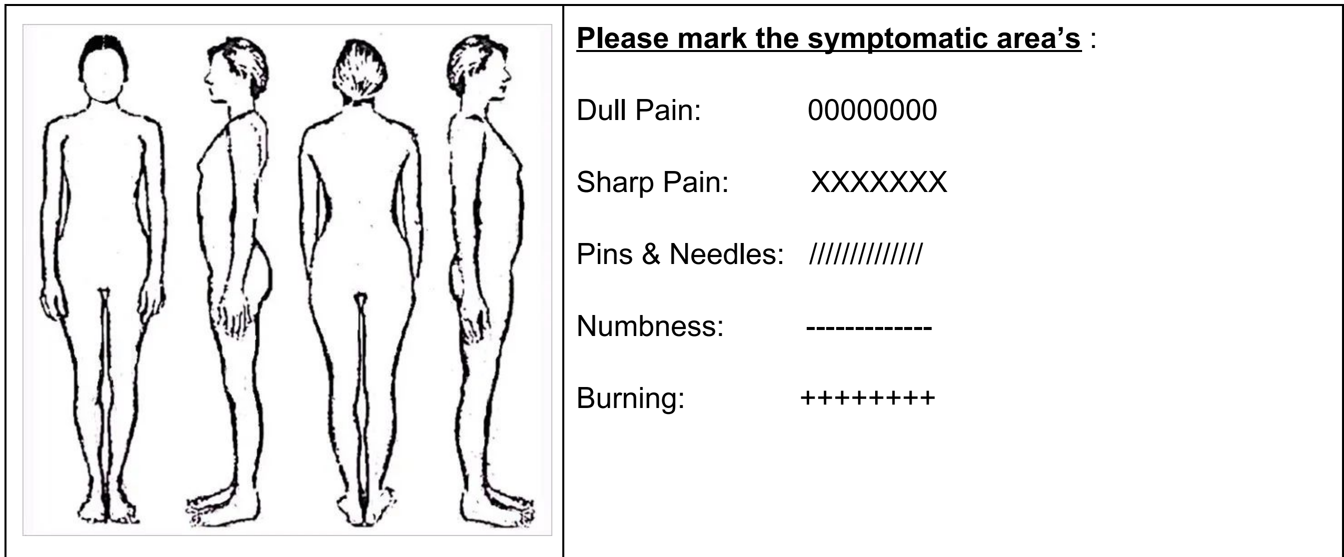
____

Have you received any medical attention for any injuries sustained in the accident or SINCE the accident: ( ) Yes / ( ) No: please explain in detail:____

____

____

Please illustrate and describe your current symptoms as of today:



Please describe in detail your current symptoms:
____

____

Since the accident have your symptoms: ( ) Improved ( ) Stayed the same ( ) Gotten worse

Please explain: ____

____

____

Your symptoms, since the accident, have prevented you from doing what: _______________

____

____

Have you lost any time off of work as a result of this automobile accident: ( ) Yes / ( ) No

#Days:____

Did you have physical complaints prior to the accident: ( ) Yes ( ) No ; Please describe:

____

____

Were you seeking medical care for those complaints listed above?: ( ) Yes ( ) No; Please explain:

____

Any other pertinent information:____

____

Signature: ____ Date: ______________

Please print name:____

Name of Legal Guardian (if applicable): ____

Signature: ____ Date: ____________