

**Personal Injury Questionnaire**

Name \_\_\_\_\_ Age \_\_\_\_\_ Phone \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Employer \_\_\_\_\_ Phone \_\_\_\_\_  
Employer's Address \_\_\_\_\_  
Vehicle Year/Make/Model \_\_\_\_\_

Were you the driver? Yes / No                      Passenger? Yes / No    Front / Back (circle)

Your Automobile Insurance \_\_\_\_\_  
Agent's Name \_\_\_\_\_ Address/Phone \_\_\_\_\_  
Other Vehicles Year/Make/Model \_\_\_\_\_  
Other Vehicle Driver's Name \_\_\_\_\_  
Their Insurance Company \_\_\_\_\_ Policy # \_\_\_\_\_  
Names of Witnesses \_\_\_\_\_

Date of Injury \_\_\_\_\_ Time \_\_\_\_\_ AM / PM  
Road Conditions \_\_\_\_\_

What direction were you headed? North / East / South / West

On What Street Name \_\_\_\_\_

Other Driver? North / East / South / West

On What Street Name? \_\_\_\_\_

In your own words please describe the collision as well as you can:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Where were you taken after the collision? \_\_\_\_\_  
\_\_\_\_\_

(please fill out both sides)

Please describe how you felt **during** the collision: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Immediately After** the collision: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Later that Day / Night : \_\_\_\_\_

\_\_\_\_\_

The **next** day: \_\_\_\_\_

\_\_\_\_\_

Have you been treated by another Doctor since the collision? YES / NO

If yes, please list Doctor's name(s) \_\_\_\_\_

Check the Symptoms noticed since injury:

- |   |  |                                       |
|---|--|---------------------------------------|
| <input type="checkbox"/> Chest Pain                   | <input type="checkbox"/> Cold Sweats         | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Headache                     | <input type="checkbox"/> Numbness in Toes    | <input type="checkbox"/> Irritability |
| <input type="checkbox"/> Neck Pain                    | <input type="checkbox"/> Numbness in Fingers | <input type="checkbox"/> Dizziness    |
| <input type="checkbox"/> Legs Tingling                | <input type="checkbox"/> Back Pain           | <input type="checkbox"/> Nervousness  |
| <input type="checkbox"/> Sleeping Problems            | <input type="checkbox"/> Flushed Face        | <input type="checkbox"/> Diarrhea     |
| <input type="checkbox"/> Pins/Needles in Arms         | <input type="checkbox"/> Fever               | <input type="checkbox"/> Cold Feet    |
| <input type="checkbox"/> Loss of Taste                | <input type="checkbox"/> Loss of Memory      | <input type="checkbox"/> Depression   |
| <input type="checkbox"/> Loss of Smell                | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Fatigue      |
| <input type="checkbox"/> Buzzing in Ears              | <input type="checkbox"/> Ringing in Ears     | <input type="checkbox"/> Fainting     |
| <input type="checkbox"/> Upset Stomach                | <input type="checkbox"/> Cold Hands          | <input type="checkbox"/> Tension      |
| <input type="checkbox"/> Loss of Balance              | <input type="checkbox"/> Head Seems Heavy    | <input type="checkbox"/> Stiff Neck   |
| <input type="checkbox"/> Pain Between Shoulder Blades |  |                                       |

Other Symptoms: \_\_\_\_\_

\_\_\_\_\_

Since this injury has occurred are your symptoms: SAME / IMPROVING / WORSE

Have you lost time from work as a result from this injury? YES / NO

How many days? \_\_\_\_\_

Have you noticed any activity restrictions as a result of this injury? YES / NO

If yes, please describe in detail: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_