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Personal Injury Questionnaire

Dear Patient, in our efforts to better serve you, please complete the following questionnaire and return it to the office. Thank you!

Name: _____ DOB: _____ Age: _____
Address: _____ City: _____ State: ____ Zip Code: _____
Phone: (home) _____ (work)_____ (cell)_____
Email Address: _____
Employer: _____ Phone: _____
Employer Address, City, State, Zip: _____
Date of Injury: _____ Location: _____
Your Auto Ins. Co.: _____ Agent: _____ Policy#: _____
Driver/Other Party: _____ Auto Ins. Co.: _____ Policy#: _____

Is there an attorney involved?
If yes, Name: _____ Phone: _____
Address: _____
Were there any witnesses?
If yes, Names: _____

Nature of Accident
What time of day did the accident take place? _____
What type of vehicle were you in? _____
What type of vehicle did the other party have? _____

Were you (check one):
(☐) Driver (☐) Passenger (☐) Front Seat (☐) Back Seat

Number of people in your vehicle? _____ Other Vehicle? _____

Was your vehicle struck from (check one):
(☐) Behind (☐) Front (☐) Left Side (☐) Right Side

Did you become unconscious?
Were the police notified?
If yes, incident report # if you have it: _____
In your own words, please describe the accident in detail:_____
_____
_____
_____

Did you have any physical complaints **BEFORE THE ACCIDENT**?
If yes, please explain in detail: _____
_____

Please describe how you felt:
DURING THE ACCIDENT: _____
LATER THAT DAY: _____
THE NEXT DAY: _____

What are your PRESENT complaints and symptoms? _____
Do you have any congenital (from birth) factors or any previous illnesses which relate to this accident? Y
If yes, please explain: _____
_____

Have you been in any previous accidents?
If yes, please explain including dates, type of accident and any injuries sustained: _____
_____

Where were you taken after your current accident? _____
Have you been treated by any other doctors for this accident?
If yes, please list names, address and the type of treatment you received: _____
_____
_____

Since the injury occurred, are you symptoms (check one):
(☐) Improving (☐) Getting Worse (☐) Same

Have you lost time from work as a result of this accident?
If yes, last date worked: _____
Are you being compensated for your lost time?
What type of compensation are you receiving? _____
Do you notice any activity restrictions as a result of this injury?
If yes, please explain: _____
_____
_____

Do you have any other pertinent information to provide relating to this injury? _____
_____

Signature: _____ Date: _____