PERSONAL INJURY QUESTIONER

Name: _____Date of Birth: _____Phone Number: _____

Email: _____Address: _____City:_____

State: _____ Zip_____

Employer's Name: _____Employer's Address: _____

Insurance Co.: _____Policy Number: _____ S.S. No: _____

Facts of the Accident:

Have you retained an attorney? ( ) Yes ( ) No Name of attorney: _____

Driver of other vehicle: _____Insurance Co:_____ Policy Number: _____

Were there any witnesses: ( ) Yes ( ) No Name(s): 1._____ 2. _____ 3. _____

1. Date of Accident: _____Time of Day: _____
2. Were you the: ( ) Driver ( ) Passenger ( ) Front Scat ( ) Back Seat
3. Number of people in your vehicle: _____ Other vehicle: _____
4. In what direction were you headed? ( ) North ( ) South ( ) East ( ) West
On what Street?_____
5. In what direction was the other vehicle headed? ( ) North ( ) South ( )East ( )West On what Street? ____
6. Were you struck from : ( ) Behind ( ) Front ( ) Left Side ( ) Right Side
7. Were you knocked unconscious? ( ) Yes ( ) NO If yes, for how long? _____
8. Were police notified? ( ) Yes ( ) No
9. In your own words, please describe the accident

_____

_____

_____

1 0.Did you have any physic complaints before the accident? ( ) Yes ( ) No If yes, Please describe in detail:

_____

_____

_____

11. Please describe how you felt at the following times:
a. DURING the accident: _____
b. IMMEDIATELY AFTER the aocident:_____
c. LATER THAT DAY: _____
d. The NEXT DAY: _____
1 2. What are you PRESENT symptoms?

_____

_____

13. Do you have any previous illnesses, which relate to this case? ( ) Yes ( ) No if yes, please describe:

_____

_____

14. Have you been involved in an accident before? ( ) Yes ( ) No If yes, please describe , including date's and type/s of accidents, as well as injuries:

_____

_____

15. Where were you taken after the accident?_____

16.Has another doctor since the accident treated you? ( ) Yes ( )No If yes, please list doctor's names and addresses: _____

17. What type of treatment did you receive _____

_____

18. Since this current injury occurred, are your symptoms: ( ) Improving ( ) Getting Worse ( ) Same

PLEA SE CHECK THE SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT:

☐ HEADACHE ☐ NEAK PAIN ☐ NECK STIFF ☐ SLEEPING PROBLEMS ☐ BACK PAIN ☐ NERVOUSNES ☐ TENSION ☐ FAINTING ☐ DIARRHEA	☐ IRRITABILITY ☐ CHEST PAIN ☐ HEAD SEEMS TOO HAVEY ☐ PINS AND NEED ARMSS ☐ PINS AND NEED LEGS ☐ NUMBNESS IN FINGERS	☐ NUMBNESS IN TOES ☐ SHORTNESS OF BREATH ☐ FATIGUE ☐ DEPRESSION ☐ LIGHTS BOTHER EYES ☐ LOSS OF MEMO ☐ LOSS OF TASTE	☐ EARS RINGING ☐ FEET COLD ☐ STOMACH UPST ☐ CONSTIPATION ☐ FEVER ☐ FACE FLUSH ☐ DIZINESS ☐ LOSS OF SMELL ☐ OTHER

Symptoms other than above: _____

Have you lost time from work as a result of this accident? ( ) Yes ( ) No If yes, please complete this question:

a. Last day of work: b. Type of employment:

c. Are you being compensated for time lost from work? ( ) Yes ( ) No If yes, please state type of compensation you are receiving: _____

Do you notice restrictions as a result of this injury? ( ) Yes ( ) No If yes, please describe in detail:

_____

_____

Other pertinent information: _____

_____

_____