PERSONAL INJURY QUESTIONNAIRE

GENERAL:

Name: Today's date: _____

Date of Birth. SSN: _____

Address: _____

_____

Phone Number: Home: _____Cell: _____

Business: _____Email: _____

Your Insurance Co. ___ _____

Claim Adjuster's Name: _____Phone No. _____

Do you have Personal Injury Protection? _____

Driver of other vehicle: _____

Other Driver Insurance Co.: _____

Other Driver's Insurance Claim Rep: _____

Do you have medical insurance? Yes ( ) No ( ) If yes, with what company? _____

_____

NATURE OF ACCIDENT:

Date of Accident: _____ Time of day: _____

Location: _____

_____

Make of your car: _____ Other car: _____

Number of people in your car: _____ In other car: _____

Were you the: Driver ( ), Passenger ( ), Front seat ( ), Back seat ( )

Were you struck from: Front ( ), Behind ( ), Left side ( ), Right side ( )

Direction you were going: N, S, E, W. On what street? _____

Direction other car was going: N, S, E, W. On what street? _____

Your approximate speed: _____Other drivers speed: _____

Please draw a picture of the car positions at the time of the accident in the space below.

In your own words, please describe the accident: _____

_____

_____

_____

_____

_____

_____

How many impacts were there? ___ ? Were police notified? _____

If yes, what police agency? _____

Was your car drivable? _____ Did you drive it away?_____

Road Conditions: _____ Weather: _____

_____

Were you wearing a seatbelt? _____ Did it have a shoulder strap? ____

Were you aware of the initial impact? Yes ( ) No ( ) If yes explain:

_____

_____

_____

Which direction were you looking at the time of the impact? _____

Position of your hands at the time of impact?

Position of your feet at the time of impact?

Did any part of your part of your body strike any parts of the car interior?

If yes, explain? _____

Were you wearing any objects that came off; (i.e.: hat, glasses, etc.) _____

Did you lose consciousness? Yes ( ) No ( )

NATURE OF TREATMENT:

Were you taken to the hospital? Yes ( ) No ( ) If yes for how long?

What treatment did you receive?_____

_____

Were x-rays taken? Yes ( ) No ( ) If yes, what body parts? _____

Have you seen any medical provider since the accident? Yes ( ) No ( ) If yes, please list below the name, address and phone number of each provider: (use back if necessary)

1) _____

_____

2) _____

_____

3) _____

_____

4) _____

_____

5) _____

_____

_____

Have you been prescribed any medication? _____

Self treatment: Have you used any of the following on your own?

( ) Ice ( ) Heating Pad ( ) Warm bath/shower ( ) Over the counter meds

( ) Stretches/exercise ( ) Braces/Support ( ) Other

NATURE OF SYMPTOMS:

Did you have any physical complaints before the accident? Yes ( ) No ( ) If yes, please describe _____

_____

Please describe how you felt:

Since the accident occurred are your symptoms: Improving ( ) Worse ( ) Same ( )
Are any of your regular activities restricted as a result of the injury? Yes ( ) No ( )
If yes, please list: _____

_____

Have you missed any time at work due to the accident or your injuries? Yes ( ) No ( )
If yes how much time?

Did you receive a note from a doctor? Yes ( ) No ( ) If yes, what Doctor? _____
Have you had any previous auto accidents? Yes ( ) No ( ) If yes, date and injuries ____

_____

Were you treated for any of these injuries? Yes ( ) No ( ) If yes, please describe type of care and duration: _____
What was the outcome of the previous auto accident?

_____

Did you have an Attorney for that auto accident? Yes ( ) No ( ) if yes, name of
Additional information that you would like our office to know:

_____

_____

_____

_____