PERSONAL INJURY QUESTIONNAIRE

Nar	ne			_ Phone () .		
Add	Iress	City		_ State	1.1.1	Zip	
Age	Birthdate	Sex	S/S #				
Em	oloyer's Name	Employer's A	ddress		1		
You	r Ins. Co Policy #		Agent's	Name			
Nar	ne on Policy (If other than self)			_ Policy #			
Res	ponsible Party's Name	<u></u>					
Add	Iress	City		_ State		Zip	
	cy Holder's Name						
ATT	ORNEY						
	ne						
Add	Iress	City		_ State		Zip	
We	re there any witnesses? () Yes () No Name	(S)					
NA	TURE OF ACCIDENT:						
1.	Date of Accident Time of Da	ay					
2.	2. Were you: () Driver () Passenger () Front Seat () Back Seat						
3.	Number of people in your vehicle? Were y	ou wearing seat belt	s?				
4.	What direction were you headed? () North () East () South () West						
	on (name of street)						
5.	. What direction was other vehicle headed? () North () East () South () West						
6.	. Were you struck from: () Behind () Front () Left side () Right side . Approximate speed of your car mph Other car mph . Were you knocked unconscious? () Yes () No If yes, for how long?						
8.							
	9. Were police notified? () Yes () No						
10.	In your own words, please describe accident:	Contraction Contraction			<u></u>		
		*					
11.	Did you have any physical complaints BEFORE TH	EACCIDENT? ())	/es ()No	lf yes, pl	ease d	escribe in detail:	
12.	Please describe how you felt:		19-51-1			1	
	a. DURING the accident:						
	b. IMMEDIATELY AFTER the accident:						
	c. LATER THAT DAY:						
	d. THE NEXT DAY:						

13.	What are your PRESENT complaints and symptoms? Do you have any congenital (from birth) factors which relate to this problem? () Yes () No If yes, please describ					
14.						
15.	Do you have any previous illnesses which relate to this case? () Yes () No If yes, please describe:					
16.	Have you ever been involved in an accident before? () Yes () No If yes, please describe, including date(s) and type(s) of accidents, as well as injury(ies) received.					
17.	Where were you taken after the accident?					
18.	. Have you been treated by another doctor since the accident? () Yes () No If yes, please list doctor's name and address:					
	What type of treatment did you receive?					
19.	Since this injury occurred, are your symptoms: () Improving () Getting Worse () Same					
20.	CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT: Headache Irritablity Numbness in Toes Face Flushed Feet Cold Neck Pain Chest Pain Shortness of Breath Buzzing in Ears Hands Cold Neck Stiff Dizziness Fatigue Loss of Balance Stomach Upset Sleeping Problems Head Seems Too Heavy Depression Fainting Constipation Back Pain Pins & Needles in Arms Lights Bother Eyes Loss of Smell Cold Sweats Nervousness Pins & Needles in Legs Loss of Memory Loss of Taste Fever Tension Numbness in Fingers Ears Ring Diarrhea					
	Symptoms Other Than Above					
21.	Have you lost time from work as a result of this accident? () Yes () No If yes, please complete this question.					
	a. Last Day Worked:					
	b. Type of Employment:					
	c. Present Salary:					
	d. Are you being compensated for time lost from work? () Yes () No If yes, please state type of compensation you are receiving:					
22.	Do you notice any activity restrictions as a result of this injury? () Yes () No If yes, please describe, in detail:					
23.	Other pertinent information:					