PERSONAL INJURY QUESTIONNAIRE

Patient's Name: _____ Date: _____

Address: _____ City: _____State: _____Zip: _____

Age: _____ D.O.B: _____ S/S#: _____ Sex Assigned At Birth: _____ Gender: _____

Home Phone: _____ Cell Phone: _____ Work Phone:_____

Email address: _____ May we contact you via e-mail? Y ___ N ___

Employer's Name: _____ Address: _____

Your Insurance Company: _____ Adjuster: _____

Claim Number: _____ Policy No: _____

Name on Policy (if other than self): _____

Date of Accident: _____ Time of Accident: _____ AM/PM

Have you contacted an insurance adjuster or representative regarding this claim? ☐ Yes ☐ No

Have you engaged services of an attorney? ☐ Yes ☐ No

Attorney: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____

Have you filed an accident/injury report? ☐ Yes ☐ No Have you filed for insurance benefits? ☐ Yes ☐ No

THE FOLLOWING QUESTIONS PERTAIN TO YOU AND THE <u>VEHICLE YOU WERE IN:</u>

Vehicle type:
☐ Car ☐ Station Wagon
☐ Van ☐ Pickup Truck
☐ Bus ☐ Large Truck
☐ Other _____

Vehicle size:
☐ Subcompact ☐ Full-Size
☐ Compact ☐ Mini
☐ Mid-size ☐ Light
☐ Heavy ☐ Other _____

Your position in the vehicle:
☐ Driver ☐ Front Passenger
☐ Left Rear Passenger
☐ Right Rear Passenger
☐ Other _____

Speed of your vehicle:
☐ Stopped ☐ Moving Moderately
☐ Parked ☐ Moving Fast
☐ Slowing ☐ Moving at approx ___MPH
☐ Moving Slowly

What was your vehicle doing at the time of the accident?
☐ Stopped in traffic ☐ Stopped at light ☐ Proceeding along
☐ Stopped at intersection ☐ Parking ☐ Other _____
☐ Making a right turn ☐ Accelerating _____
☐ Making a left turn ☐ Slowing down _____

Collision Type: ☐ Driver Side Impact ☐ Passenger Side Impact ☐ Front Impact ☐ Head On Collision
☐ Rear Impact ☐ Pedestrian Incident

THE FOLLOWING QUESTIONS CONCERN THE <u>OTHER VEHICLE</u> INVOLVED IN THE ACCIDENT:

Vehicle type:
☐ Car ☐ Station Wagon
☐ Van ☐ Pickup Truck
☐ Bus ☐ Large Truck
☐ Other _____

Vehicle size:
☐ Subcompact ☐ Full-Size
☐ Compact ☐ Mini
☐ Mid-size ☐ Light
☐ Heavy ☐ Other _____

PLEASE DESCRIBE IN YOUR OWN WORDS WHAT HAPPENED:

CONDITIONS AT THE TIME OF THE ACCIDENT:

Time of day:	**Road Conditions:**	**Visibility:**	**If visibility was poor, why?**
☐ Daylight	☐ Dry	☐ Excellent	☐ Brightness ☐ Snow
☐ Dawn	☐ Damp	☐ Good	☐ Darkness ☐ Fog
☐ Dusk	☐ Wet	☐ Fair	☐ Rain ☐ Traffic
☐ Other _____	☐ Snow Covered	☐ Poor	☐ Snow ☐ Other _____
	☐ Icy		
	☐ Other _____		

THE FOLLOWING QUESTIONS CONCERN THE MOMENT OF THE IMPACT OF THE ACCIDENT:

Were you:	**Was your foot on the brake pedal?**	**Restraints:**
☐ Totally unaware that the accident was impending	☐ Yes	☐ Seat belt
☐ Aware that the accident was impending	☐ No	☐ Shoulder harness
☐ Aware that the accident was impending and braced for impact	☐ Knocked off by impact	☐ No restraints

Was the air bag deployed?	**What position was YOUR headrest in?**	**Position of your BODY at time of impact?**
☐ Car not equipped with air bags	☐ High position ☐ Unsure	☐ Facing straight ahead
☐ Air bag deployed	☐ Middle position	☐ Tilted forward
☐ Air bag did not deploy	☐ Low position	☐ Rotated to the left
		☐ Rotated to the right

Was your BODY thrown...?	**Position of your HEAD at time of impact?**	**Was your HEAD thrown?**
☐ Backward and then forward	☐ Facing straight ahead	☐ Backward and then forward
☐ Forward then backward	☐ Tilted forward	☐ Forward then backward
☐ To the left ☐ To the left, then the right	☐ Rotated to the left	☐ To the left ☐ To the left, then the right
☐ To the right ☐ To the right, then the left	☐ Rotated to the right	☐ To the right ☐ To the right, then the left
☐ Across vehicle ☐ Outside vehicle		
☐ Under vehicle ☐ Don't recall		

Damage to vehicle YOU were in:	**Were Citations issued?**
☐ Minimal damage	☐ None issued
☐ Moderate damage	☐ Yourself
☐ Severe damage	☐ Driver of vehicle you were in
☐ Totaled	☐ Driver of other vehicle
☐ Not known	☐ Not sure

AS A RESULT OF THE FORCE OF THE COLLISION, WHICH OBJECTS IN THE VEHICLE DID YOUR BODY STRIKE?

Head:	**Left Arm:**	**Right Arm:**	**Torso:**
☐ Steering wheel	☐ Steering wheel	☐ Steering wheel	☐ Steering wheel
☐ Dashboard	☐ Dashboard	☐ Dashboard	☐ Dashboard
☐ Windshield	☐ Windshield	☐ Windshield	☐ Windshield
☐ Armrest	☐ Armrest	☐ Armrest	☐ Armrest
☐ Headrest	☐ Headrest	☐ Headrest	☐ Headrest
☐ Rear view mirror	☐ Rear view mirror	☐ Rear view mirror	☐ Rear view mirror
☐ Left door	☐ Left door	☐ Left door	☐ Left door
☐ Right door	☐ Right door	☐ Right door	☐ Right door
☐ Left window	☐ Left window	☐ Left window	☐ Left window
☐ Right window	☐ Right window	☐ Right window	☐ Right window
☐ Console	☐ Console	☐ Console	☐ Console
☐ Gear shift	☐ Gear shift	☐ Gear shift	☐ Gear shift
☐ Front seat	☐ Front seat	☐ Front seat	☐ Front seat
☐ Backseat	☐ Backseat	☐ Backseat	☐ Backseat
☐ Ceiling	☐ Ceiling	☐ Ceiling	☐ Other _____
☐ Other _____	☐ Other _____	☐ Other _____	

Left Leg:		**Right Leg:**	
☐ Steering wheel	☐ Left window	☐ Steering wheel	☐ Left window
☐ Dashboard	☐ Right window	☐ Dashboard	☐ Right window
☐ Windshield	☐ Console	☐ Windshield	☐ Console
☐ Armrest	☐ Gear shift	☐ Armrest	☐ Gear shift
☐ Headrest	☐ Front seat	☐ Headrest	☐ Front seat
☐ Rear view mirror	☐ Backseat	☐ Rear view mirror	☐ Backseat
☐ Left door	☐ Other _____	☐ Left door	☐ Other _____
☐ Right door		☐ Right door	

THE FOLLOWING QUESTIONS CONCERN THE TIME PERIOD IMMEDIATELY FOLLOWING THE ACCIDENT:

Did you lose consciousness?
☐ Yes
☐ No
☐ Don't Know

Immediately following the accident, how did you feel?
☐ Confused ☐ Disoriented ☐ Angry
☐ Dizzy ☐ Weak ☐ Shocked
☐ Dazed ☐ Nervous
☐ Nauseated ☐ Other _____

Were you able to walk unaided?
☐ Yes
☐ No

Where did you go?
☐ Hospital
☐ School
☐ Home
☐ Work
☐ Other _____

By whom were you driven?
☐ Myself
☐ Friend
☐ Ambulance
☐ Family member
Other _____

Next day discomfort?
☐ Increased
☐ Decreased
☐ Same

Did your major complaints exist before the accident?
☐ Yes
☐ No

In what areas did you IMMEDIATELY feel pain?

☐ Head	☐ L ☐ R	Shoulder
☐ Neck	☐ L ☐ R	Arm
☐ Upper Back	☐ L ☐ R	Elbow
☐ Mid Back	☐ L ☐ R	Wrist
☐ Ribs	☐ L ☐ R	Hand
☐ Chest	☐ L ☐ R	Fingers
☐ Abdomen	☐ L ☐ R	Buttock
☐ Low Back	☐ L ☐ R	Hip
☐ Pelvis	☐ L ☐ R	Thigh
	☐ L ☐ R	Knee
	☐ L ☐ R	Calf
	☐ L ☐ R	Ankle
	☐ L ☐ R	Foot
	☐ L ☐ R	Toes

If there were lacerations (cuts), where were they?

☐ Head	☐ L ☐ R	Shoulder
☐ Neck	☐ L ☐ R	Arm
☐ Upper Back	☐ L ☐ R	Elbow
☐ Mid Back	☐ L ☐ R	Wrist
☐ Ribs	☐ L ☐ R	Hand
☐ Chest	☐ L ☐ R	Fingers
☐ Abdomen	☐ L ☐ R	Buttock
☐ Low Back	☐ L ☐ R	Hip
☐ Pelvis	☐ L ☐ R	Thigh
	☐ L ☐ R	Knee
	☐ L ☐ R	Calf
	☐ L ☐ R	Ankle
	☐ L ☐ R	Foot
	☐ L ☐ R	Toes

Did you receive emergency care?
☐ Yes ☐ No

What type of emergency care did you receive?
☐ Bandages
☐ Splints
☐ Brace
☐ Neck collar
☐ Other _____

When did you go to the hospital?
☐ Immediately
☐ Later that day
☐ Next day
☐ Days later
☐ Date _____
☐ Other _____

Hospital Name _____

Examined by Dr. _____

Admitted? ☐ Yes ☐ No

Date discharged _____

What treatment was performed? _____

What diagnosis was given? _____

Have you been for consultation/treatment anywhere else? Y / N

Facility Name: _____**Dr. Name:**_____

What treatment was performed? _____

What diagnosis was given? _____

At the hospital, what areas were x-rayed?

☐ Head	☐ L	☐ R	Shoulder
☐ Neck	☐ L	☐ R	Arm
☐ Upper Back	☐ L	☐ R	Elbow
☐ Mid Back	☐ L	☐ R	Wrist
☐ Ribs	☐ L	☐ R	Hand
☐ Chest	☐ L	☐ R	Fingers
☐ Abdomen	☐ L	☐ R	Buttock
☐ Low Back	☐ L	☐ R	Hip
☐ Pelvis	☐ L	☐ R	Thigh
	☐ L	☐ R	Knee
	☐ L	☐ R	Calf
	☐ L	☐ R	Ankle
	☐ L	☐ R	Foot
	☐ L	☐ R	Toes

What treatment was administered at the hospital?

☐ Oral medication	☐ Ice packs	☐ Collar
☐ Injection	☐ Hot packs	☐ Support
☐ Topical antiseptics	☐ Splint	☐ Surgery
☐ Bandages	☐ Cast	☐ Other_____
☐ Sutures	☐ Brace	_____

Instructions given when discharged from hospital:
Who were you told to see?

☐ General Practitioner	☐ General Surgeon
☐ Chiropractor	☐ Orthopedist
☐ Physical Therapist	☐ Neurologist
☐ Plastic Surgeon	☐ Internist
☐ Other _____	

What recommendations were made?

☐ No Further Care	☐ Ice	☐ Time Off Work
☐ No Follow Up Instructions	☐ Heat	☐ Other _____
☐ Observation	☐ Collar	
☐ Rest	☐ Support	

Were medications prescribed?

☐ Pain	☐ Other _____
☐ Anti-Inflammatory	
☐ Antibiotic	

How much later did additional symptoms develop?

- ☐ Immediately
- ☐ Hours
- ☐ That Evening
- ☐ Next Morning
- ☐ Days
- ☐ Week
- ☐ Month
- ☐ Other _____

What additional symptoms developed? Please describe:

Since your accident/injury have you suffered from?

☐ Blurred Vision	☐ Constipation
☐ Double Vision	☐ Diarrhea
☐ Reduced Vision	☐ Nausea
☐ Impaired Hearing	☐ Vomiting
☐ Ringing in Ears	☐ Frequent Urination
☐ Chest Pain	☐ Inability to Hold Urine
☐ Difficulty Breathing	☐ Painful Urination
☐ Palpitations	

Additionally, have you experienced any of the following?

☐ Anxiety	☐ Loss of Balance
☐ Depression	☐ Fatigue
☐ Mood Swings	☐ Restlessness
☐ Nervousness	☐ Insomnia
☐ Poor Memory	☐ Light Sensitivity
☐ Tension	☐ Reduced Appetite
☐ Convulsions	☐ Weakness
☐ Dizziness	☐ Weight Gain
☐ Headaches	☐ Weight Loss
☐ Fainting	☐ Other _____

Are you restricted in any of the following areas as a result of this accident/injury?

- ☐ Daily Living
- ☐ Occupation/Work
- ☐ Recreational Activities
- ☐ Other _____

Did you seek medical care elsewhere? If so, who did you see and what care did you receive?
Dr. _____
Type of Physician: _____
Diagnosis and Treatment:
_____

Patient's or Guardian Signature: _____ Date: _____