Claim Number.....

PERSONAL INJURY QUESTIONNAIRE

Name:..... DOB .....Phone .....

Address: .....

City..... State.....Zip.....

Employer's Name ..... Employer's Address .....

Your insurance company ..... Policy number.....

Have you made a claim with your insurance company? □ Yes □ No Claim number.....

Who is your adjuster? ..... Phone number.....

Have you retained an attorney? □ Yes □ No Attorney and firm name.....

..... Address .....

City..... State ..... Zip..... Phone number.....

INFORMATION ABOUT THE ACCIDENT

1. Date of Accident .....Time of Day..... am or pm State.....

2. Road conditions at the time of the accident? □ Covered with gravel □ Covered with leaves or other debris
   □ Dry □ Damp □ Mostly dry with first minutes of rain □ Muddy □ Sandy □ Wet
   □ Covered with Snow □ Covered with ice

3. Visibility at the time of the accident? □ Excellent with bright sunlight □ Excellent with overcast light
   □ Reduced at dawn □ Reduced at dusk □ Reduced at night □ Reduced due to fog □ Reduced due to rain
   □ Reduced due to snow □ Reduced due to sun glare □ Other.....

4. Who hit who?
   □ My vehicle was hit by more than one other vehicle □ My vehicle was hit by the other vehicle
   □ My vehicle hit the other vehicle □ My vehicle hit more than one other vehicle

5. Did the Police come to the accident scene? □ Yes □ No Is there a Report? □ Yes □ No
   Were citations issued by the Police? □ Yes □ No If yes, who?.....

YOUR VEHICLE

7. Were you: □ Driver □ Passenger □ Front Seat □ Back Seat (circle one) Right side Left Side

8. Number of people in the vehicle?.....

Patient Name .....**Date** .....**Claim Number** .....

9. What type of vehicle were you in?
   □ Car (choose one) compact medium full sized
   □ Passenger truck (choose one) compact medium full sized
   □ Motorcycle □ Mini Van □ Semi tractor □ Semi tractor-trailer □ Passenger Van or Bus

10. Where was the point of impact on your vehicle? (*e.g. left rear passenger door*) Please be specific.....
    .....

11. Was your car stopped at the time of the impact? □ Yes □ No
    If yes, was the driver's foot on the brake? □ Yes □ No
    If so, did the driver's foot remain on the brake throughout the impact? □ Yes □ No
    If no, estimate the speed of the vehicle you were in.....mph
    If your vehicle was moving at the time of impact, was it?
    □ Slowing down □ Gaining speed □ Traveling at a steady speed

THE OTHER VEHICLE

12. What type of vehicle was the other vehicle?
    □ Car (choose one) compact medium full sized
    □ Passenger truck (choose one) compact medium full sized
    □ Motorcycle □ Mini Van □ Semi tractor □ Semi tractor-trailer □ Passenger Van

13. Where was the point of impact on the other vehicle? (*e.g. driver's door, rear ended straight on*) Please be specific.....
    .....

14. Was the other vehicle moving at the time of the collision? □ Yes □ No
    If yes, what was the approximate speed? .....Mph

15. If the other vehicle was moving at the time of the collision, was it?
    □ Slowing down □ Gaining speed □ Traveling at a steady speed

THE IMPACT

16. Were you aware of the approaching collision prior to impact, or did the impact catch you by surprise?
    □ Aware □ Surprised

17. Was the trunk of your body pointed straight forward at the time of the collision? □ Yes □ No
    If no, how was it turned? □ Left □ Right □ Other.....

Patient Name ..... **Date** ..... **Claim Number** .....

18. Was your head pointed straight forward at the time of the collision? □ Yes □ No
    If no, what direction was it turned and by how much? □ Down ..... □ Down and to left .....
    □ Down and to right ..... □ Level and to left ..... □ Level and to right .....
    □ Up ..... □ Up and to left ..... □ Up and to right .....

19. Did air bags deploy? □ Yes □ No
    If yes, which ones? .....

20. How was your headrest adjusted? □ Improperly adjusted and provided negligible protection
    □ Properly adjusted □ High □ All the way up □ Low □ All the way down

21. Did you lose consciousness? □ Yes □ No If yes, for how long? .....

22. Did you lose glasses, dentures or a hair piece if you wear any of them? □ Yes □ No
    If yes, which □ Glasses □ Dentures □ Hair piece

23. Did any part of your body hit anything inside the automobile? □ Yes □ No If yes, please check appropriate box(es) below, and state which part(s) of the vehicle your body made contact with.
    □ Head hit ..... □ Chest hit .....
    □ Right / left shoulder hit ..... □ Right / left arm hit .....
    □ Right / left hip hit ..... □ Right / left leg hit .....
    □ Right / left knee hit ..... □ Other.....

24. Were you wearing a seatbelt? □ Yes □ No If yes, was it? □ a lap seat belt □ shoulder-lap seat belt

25. Did you receive any injury or bruise from the seat belt? □ Yes □ No If yes, describe .....
    .....

26. What bleeding cuts did you sustain during this accident? .....
    What bruises? .....

27. Please describe how you felt:
    a) During the accident.....
    b) Immediately after the accident .....
    c) Later that day.....
    d) The next day .....

AFTER THE IMPACT

28. After the impact did you become? □ Confused □ Disoriented □ Light headed □ Dizzy
    □ Nauseated □ Blurred Vision □ Ringing/Buzzing in ears □ Experience headaches

Patient Name .....**Date** .....**Claim Number** .....

29. Do you still experience any of these symptoms? □ Yes □ No If yes, which ones? .....
.....

30. In your own words, describe the accident .....
.....
.....
.....
.....
.....

WHAT ABOUT TREATMENT?

31. Were you treated at the scene of the accident? □ Yes □ No If yes, what was done and by whom? .....
.....

32. Did you go to the hospital? □ Yes □ No If yes, name and city of hospital.....
How did you get to the hospital?.....
Did the hospital perform any imaging of your body?.....
If yes, what type of imaging and to what part/s of your body? .....
What did the hospital tell you to do next?.....

33. Have you been treated by another doctor since the accident? □ Yes □ No
If yes, list name(s) and address (es).....
.....
.....
What type of treatment did you receive?.....

34. Do you have a primary care physician (PCP)? □ Yes □ No If yes, who?.....
Have you seen your PCP since the accident? □ Yes □ No If yes, when?.....

BEFORE THE ACCIDENT

35. Did you have any physical complaints before the accident? □ Yes □ No If yes, please describe in detail: .....
.....
.....
.....

36. Do you have any congenital (from birth) factors which relate to this problem? □ Yes □ No If yes, describe
.....
.....

Patient Name .....**Date** .....**Claim Number** .....

37. Do you have any previous illnesses which relate to this case? (*e.g. an illness that has been exacerbated by the accident*). Please describe.....
.....
.....
.....

38. 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) sustained:.....
.....
.....

HOW DO YOU FEEL NOW?

39. What are your present complaints and symptoms? .....
.....
.....
.....
.....

40. Check the symptoms that you have noticed SINCE THE ACCIDENT:

□ Headache	□ Irritability	□ Numbness in toes	□ Face flushed	□ Feet cold
□ Neck Pain	□ Chest Pain	□ Short 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	□ Light bothers 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	□ Other .....

.....

EMPLOYMENT CHALLENGES AND OR PHYSICAL RESTRICTIONS

41. Have you lost time from work as a result if this injury? □ Yes □ No If yes, please complete this question:
    a) First day/date off work .....
    b) Have you been off work continuously since the accident? □ Yes □ No
    c) If no, what day/date did you return to work? .....
    d) Type of employment .....

Patient Name .....**Date** .....**Claim Number** .....

42. Do you notice any activity or work restrictions as a result of this injury? □ Yes □ No If yes, please describe in detail

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43. Other pertinent information.....

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Patient Signature: .....**Date**.....