PERSONAL INJURY QUESTIONNAIRE

Name:_____ Date:_____

1. Date of accident: _____ Time of Day: _____ ☐ AM ☐ PM
2. Were you: ☐ Driver ☐ Passenger ☐ Front Seat ☐ Back Seat
3. Number of people in the vehicle: _____ Number of people in other vehicle: _____
4. Road conditions at time of accident: ☐ Wet ☐ Dry ☐ Icy ☐ Other: _____
5. Were you struck from: ☐ Behind ☐ Front ☐ Left Side ☐ Right Side
6. Were you wearing a seat belt? ☐ Yes ☐ No
   If yes:
   a. ☐ Lap Belt Only
   b. ☐ Shoulder and Lap Belt
   c. ☐ Shoulder Belt Only
7. Did you sustain any bruising or soreness from the seatbelt? ☐ No ☐ Yes If Yes, Explain: _____
8. What was your position at the time of impact? ☐ Facing forward ☐ Head turned ☐ Left Side ☐ Right Side
9. Does your car have a headrest? ☐ Yes ☐ No If Yes, approximately how far was the top of the headrest from the top of your head? _____ inches ☐ Above ☐ Below
10. Were you knocked unconscious? ☐ Yes ☐ No If Yes, for how long?_____
11. Were you aware of the approaching collision prior to impact? ☐ Yes ☐ No
12. Was your car stopped at the time of impact? ☐ Yes ☐ No
    If Yes:
    a. Was the driver's foot on the brake pedal? ☐ Yes ☐ No
    b. Did your car move forward upon impact? ☐ Yes ☐ No
    If No:
    c. Were you: ☐ Gaining speed ☐ Slowing down ☐ Traveling the speed limit
    ☐ Driving Slow ☐ Driving Fast
13. Did your vehicle strike another vehicle? ☐ Yes ☐ No
14. Did your vehicle strike another object? ☐ Yes ☐ No If yes, what? _____
15. Was the other vehicle moving at the time of the collision? ☐ Yes ☐ No
    a. If yes: The vehicle was traveling ☐ slow ☐ medium ☐ fast at the time of the accident.
    b. If yes: The vehicle was ☐ gaining speed ☐ slowing down ☐ traveling steadily at the time of the accident.
16. Make and Model of your vehicle: _____
17. Make and Model of other vehicle: _____
18. Describe the accident, including what you saw, heard and/or felt:_____
    _____
    _____
19. Describe how you felt: _____
20. Did you feel pain? ☐ Yes ☐ No If yes, what? _____
    During the accident: _____
    Immediately after the accident: _____
    Later that day: _____
    The next day: _____
21. What is the estimated cost of damage to your vehicle: _____ Do you have photos of the damage? ☐ Yes ☐ No
22. On what part of the automobile did the following body parts hit:

Head	_____	Right / Left Arm	_____
Chest	_____	Right / Left Leg	_____
Right / Left Hip	_____	Right / Left Knee	_____
Right / Left Shoulder	_____	Other:	_____

23. Did the air bag(s) deploy? ☐ No ☐ Yes If yes, what part of your body hit the air bag?_____
24. Did it leave a bruise? ☐ Yes ☐ No
25. Which of the following car parts broke during the accident:
    - ☐ Windshield
    - ☐ Right / Left Side Window
    - ☐ Steering Wheel
    - ☐ Front / Back Seat
    - ☐ Other(s): _____
26. Did you have any physical complaints BEFORE THE ACCIDENT? ☐ Yes ☐ No If yes, describe in detail:
    _____
27. What are your PRESENT complaints and symptoms? _____
    _____
28. Do you have any congenital (from birth) factor(s) which relates to this problem? ☐ Yes ☐ No
    If yes, describe in detail:
    _____
29. Do you have any previous illnesses relating to this case? ☐ Yes ☐ No If yes, describe in detail:
    _____
30. Have you ever been involved in an accident before? ☐ Yes ☐ No If yes, please describe:
    _____
31. Did you receive any medical care following the accident? ☐ Yes ☐ No If yes, where, what type of treatment and doctor's name: _____
32. Have you been treated by another doctor since the accident? ☐ Yes ☐ No If yes, list doctor's name and contact info: _____
    What type of treatment did you receive?_____
33. Since this injury occurred, are your symptoms: ☐ Improving ☐ Getting Worse ☐ Same
34. CHECK SYMPTOMS THAT YOU HAVE NOTICED SINCE THE ACCIDENT (Check all that apply):

☐ Headache	☐ Shoulder Pain	☐ Dizziness	☐ Sleeping Problems	☐ Ears Ring
☐ Neck Pain	☐ Elbow Pain	☐ Fainting	☐ Head Seems Too Heavy	☐ Face Flushed
☐ Neck Stiffness	☐ Wrist Pain	☐ Fever	☐ Pins & Needles in Arms	☐ Cold Sweats
☐ Upper Back Pain	☐ Arm Pain	☐ Diarrhea	☐ Pins & Needles in Legs	☐ Depression
☐ Mid Back Pain	☐ Leg Pain	☐ Constipation	☐ Numbness in Fingers	☐ Nervousness
☐ Low Back Pain	☐ Chest Pain	☐ Irritability	☐ Numbness in Toes	☐ Cold Feet
☐ Hip Pain	☐ Loss of Taste	☐ Fatigue	☐ Shortness of Breath	☐ Cold Hands
☐ Knee Pain	☐ Loss of Smell	☐ Bright Light Sensitivity	☐ Emotions Out of Control	
☐ Foot Pain	☐ Loss of Balance	☐ Loss of Memory	☐ Other:	

35. Employer: _____ Type of Employment: _____
36. Have you lost time from work as a result of this accident? ☐ Yes ☐ No
    If yes, when was the last day worked: _____ # of days missed: _____
    If yes, are you being compensated for time lost from work? ☐ Yes ☐ No
    If yes, type of compensation you are receiving: _____
37. Do you notice any activity restrictions in your capacity for work, family or recreational pursuits as a result of this injury? ☐ Yes ☐ No If yes, describe in detail:
    _____
38. Other pertinent information: _____
    _____
    _____