

PERSONAL INJURY QUESTIONNAIRE (Auto Accident)

NAME: _____ Acct#: _____ Date: _____

Have you filed a claim with an insurance company? Yes No

Date of Accident: _____ Where did the accident happen? Describe the accident in your own words:

What was your position in the car?

Driver: If Driver were your hands on the steering wheel? Left Right Both
Passenger: If passenger, were you sitting in Front Right Rear Left Rear?
Did your vehicle strike another vehicle? Yes No
Was your vehicle struck by another vehicle? Yes No
Angles of impact... First Collision: Front Back Left Right
If Second Collision: Front Back Left Right
Were you wearing a seat belt? Yes No
Did you brace for impact? Yes No ... I braced with my hands I braced with my feet
Which way were you facing at the time of impact... straight ahead Left Right

Did you strike anything in vehicle at time of impact? Yes No
If yes, specify what part of your body struck what: ie... Head, Chest, Chin, Shoulder Right / Left, Knee
Steering Wheel _____ Dashboard _____
Windshield _____ Roof _____
Left Side Door _____ Right Side Door _____
Left Side Window _____ Right Window _____
Other _____

Did the seat back bend / break? Yes No
Immediately following the accident, how did you feel? dizzy/dazed disoriented unconscious
nervous nauseous upset weak other _____

Did you go to the hospital? Yes No Were you admitted to the hospital? Yes No
If yes, how long? _____

If you went to hospital, when? At time of accident Next day
How did you get to hospital? Ambulance Police Car Private Transportation
Name of Hospital: _____
Attended by Dr. _____

What treatment was given?
 none placed in a cervical collar x-rayed given stitches bandaged
 given pain medication given instructions regarding concussions
 given instructions regarding sprains and strains physical therapy
 instructed to call an orthopedic surgeon instructed to call a private physician
 referred to this office for treatment other _____

Have you seen any other doctor as a result of this accident? Yes No Doctor's name _____

CHIEF Complaints or Symptoms:

Neck Pain none left shoulder left arm left forearm left hand
check off the areas that the right shoulder right arm right forearm right hand
pain runs into from the neck

Are you experiencing..

Headache
 Migraine Headache
 Upper back pain

Ringing in Ears Yes No Left Right Both Ears
Blurry Vision Yes No Left Right Both Eyes
Wrist Pain Yes No Left Right Both Wrists
Jaw Pain Yes No Left Right Both Sides

dizziness nervousness fatigue anxiety depression excessive irritability
 fear of driving in a car a loss of concentration jaw clenching grinding of teeth at night
 nightmares difficulty with sleeping at night

Low Back Pain none buttocks left buttock left thigh left knee
select the areas of radiation, if left foot right buttock right thigh right knee right foot
any...

Hip Pain Left Right Bilateral
Knee Pain Left Right Bilateral
Foot Pain Left Right Bilateral

Numbness:

Left Hand Left Upper Arm Right Hand Right Upper Arm
 Left Foot Left Leg Right Foot Right Leg

Additional Symptoms/ Complaints: _____

Have you lost any time from work due to your injuries? Yes No

If yes please give dates: _____

Type of employment: _____

Have you had previous injuries or accidents? Yes No

Description of previous Accident: _____

Description of previous injuries: _____

Is there any residual pain from the previous injury? Yes No

How much better did you feel prior to your current condition? (Example 100%, 80% etc.) _____

Signature: _____

Date: _____