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PERSONAL INJURY QUESTIONNAIRE

Name _____ Date _____

Address _____ Phone #: _____

SSN _____ Date of Birth _____

Were you performing job related duties when this accident occurred? Yes No

Date of Accident _____ Time of Accident _____

Do you have PIP Insurance? Yes No Your Insurance Company _____

Claim # _____ Policy Number _____

Other Driver's Insurance Company _____ Policy # _____

Please describe the accident in your own words: _____

Were you the Driver Rear Passenger Front Passenger Other

How many people were in your vehicle? _____

Other Vehicle? _____

ACCIDENT SITE

Road / Street Name _____

City / State _____

Nearest Intersection with road/street _____

Driving Conditions Dry Wet Icy Other

Which direction were you headed? _____

Speed you were traveling? _____

VEHICLE

Make, model and year of vehicle you were in: _____

Were you wearing a seatbelt? Yes No

If yes, what type? Lap Shoulder

Was vehicle equipped with airbags? Yes No

If yes, did they inflate properly? Yes No

Did your seat have a headrest? Yes No

OTHER VEHICLE

Make and model of other vehicle _____

Which direction was other vehicle headed? _____

Approximate speed other vehicle was traveling _____

IMPACT

Did your car impact another vehicle? Yes No

Did your car impact a structure? _____

Did any part of your body strike anything in the vehicle? Yes No If yes, explain _____

Was impact from : Front Rear Left Right

At the time of impact were you?

Looking straight ahead Looking to the right

Looking to the left Looking down

Looking up

Were both hands on the steering wheel? Yes No

Was your foot on the brake? Yes No

Were you: Surprised by impact Braced for impact

POLICE

Did the police come to the accident site? Yes No

Were there any witnesses? Yes No

Was a police report filed? Yes No

Was a traffic violation issued? Yes No

If yes, to whom? _____

PATIENT CONDITION

Were you unconscious immediately after the accident? Yes No If yes, for how long? _____

Please describe how you felt immediately after the accident: _____

TREATMENT

Did you go to the hospital? Yes No

When did you go? Immediately after the accident Next Day 2 days or more after the accident

How did you get to the hospital? Ambulance Private transportation

Name of treating Doctor _____

Diagnosis _____

Treatment received _____

X-rays taken _____

SYMPTOMS/INJURIES

Have you been able to work since the injury? Yes No How many work days have you missed? _____

Prior to the injury were you able to work on an equal basis with others your age? Yes No

If you have had any of the following symptoms since your injury, please indicate

- | | | |
|---|--|---|
| <input type="radio"/> Arm/shoulder pain | <input type="radio"/> Feet/toe numbness | <input type="radio"/> Neck pain |
| <input type="radio"/> Back pain | <input type="radio"/> Hand/finger numbness | <input type="radio"/> Neck stiff |
| <input type="radio"/> Back stiffness | <input type="radio"/> Headaches | <input type="radio"/> Shortness of breath |
| <input type="radio"/> Chest pain | <input type="radio"/> Irritability | <input type="radio"/> Sleep difficulty |
| <input type="radio"/> Dizziness | <input type="radio"/> Jaw problems | <input type="radio"/> Stomach upset |
| <input type="radio"/> Ear buzzing | <input type="radio"/> Leg pain | <input type="radio"/> Tension |
| <input type="radio"/> Ear ringing | <input type="radio"/> Memory loss | <input type="radio"/> Vision blurred |
| <input type="radio"/> Fatigue | <input type="radio"/> Nausea | |

Is this condition getting progressively worse? Yes No Unknown

Rate the severity of your pain on a scale from 1 (least pain) to 10 _____

Type of pain: Sharp Dull Throbbing Numbness
 Aching Shooting Burning Tingling
 Cramps Stiffness Swelling Other _____

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your: Work Sleep Daily Routine

Recreation

Activities or movements that are painful to perform:

- Sitting Standing Walking Bending Lying down

I certify that the above information is correct to the best of my knowledge.

As part of our collection practices, we reserve the right to invoke the use of a medical lien.

Patient Signature _____ Date _____