Personal Injury Questionnaire

Name_____ Date of birth_____ Phone_____

Address_____ City/State/Zip_____

Insurance

Your insurance company_____ Policy #_____

Address_____ Agent_____

Claim #_____ Phone_____ Fax_____

Have you notified your agent that you are being treated for injuries due to this accident? Yes_____ No_____. If you have not please call today so PIP (personal injury protection) claim number can be assigned.

Vehicle information

Your vehicle:

Make_____ Model_____

Number of people in vehicle _____ Approximate speed of your vehicle_____

Other vehicle:

Make_____ Model_____

Number of people in vehicle_____ Approximate speed of other vehicle_____

Police information

1) Were police notified? ( ) Yes ( ) No

2) Who was found at fault in the collision? ( ) You ( ) Your driver ( ) The driver of the other vehicle ( ) Other

3) Did anyone receive a ticket? ( ) Yes ( ) No ( ) Don't know Who?_____

Accident information

1) Date of accident_____ Time of day_____

2) Were you: ( ) Driver ( ) Passenger ( ) Front Seat ( ) Back Seat

3) Number of people in your vehicle? _____

4) Were you wearing a seatbelt? ( ) Yes ( ) No

5) Was the headrest of your seat: ( ) Properly adjusted ( ) Maladjusted ( ) Unadjustable ( ) No headreast

6) Upon impact was you vehicle: ( ) Moving ( ) Stationary

7) In what direction was your vehicle traveling? ( ) North ( ) South ( ) East ( ) West

On (name of street)_____

8) In what direction was the other vehicle traveling? ( ) North ( ) South ( ) East ( ) West

On (name of street)_____

9) What were the road conditions?_____

10) Were you struck from: ( ) Behind ( ) Front ( ) Left Side ( ) Right Side ( ) Other

11) Was there more than one impact involved (did you hit another vehicle or object)? ( ) Yes ( ) No

12) Did any part of you strike anything in the car or did anything strike you? ( ) Yes ( ) No

If yes, please explain:_____

13) At the time of impact were you looking: ( ) Straight ( ) Left ( ) Right ( ) Up ( ) Down ( ) Other

If Other, please explain:_____

14) Were you aware of the impending collision? ( ) Yes ( ) No

15) Estimated damage to your vehicle?_____

16) Did your vehicle spin out of control? ( ) Yes ( ) No

17) Did you receive any bruises, cuts, abrasions, broken bones, etc. as a result of the collision? ( ) Yes ( ) No

If yes, please describe_____

18) Were you knocked unconscious? ( ) Yes ( ) No If Yes, for how long?_____

19) Where were you taken after the accident?_____

If you were taken to a hospital, please answer the following questions.

a. Were you taken to a local emergency room? ( ) Yes ( ) No If yes, was it by ambulance? ( ) Yes ( ) No

b. Were you treated and released that day? ( ) Yes ( ) No

c. Were you admitted as an in-patient in the hospital? ( ) Yes ( ) No If yes, for how long?_____

d. Were x-rays taken? ( ) Yes ( ) No Did you receive any braces, etc? ( ) Yes ( ) No

20) In your own words please describe the accident:

_____

_____

_____

_____

_____

21) Have you lost time from work as a result of this accident? ( ) Yes ( )No If yes, how much time?_____

22) Describe how your current injuries and symptoms affect your ability to work?

_____

_____

_____

23) Please describe any activity restrictions as a result of this injury. (lifting, bending, walking, sports, family,sleep, etc…)

_____

_____

_____

_____

_____

Symptoms/Injuries

1) Please list all the symptoms you are currently experiencing and assign each of them a number from 1-10, with 10 being the most severe.

1._____	7._____	13._____
2._____	8._____	14._____
3._____	9._____	15._____
4._____	10._____	16._____
5._____	11._____	17._____
6._____	12._____	18._____

3) Is condition: ( ) Improving ( )Same ( )Getting worse

4) How often does pain occur? (ex: frequent, constant, occasional) _____

2) What, if any, symptoms were present before the accident (also assign each a number from 1-10 depending on severity)?

_____
_____
_____

3) Were you under previous care for any of these pre-existing symptoms? ( ) Yes ( ) No

4) Have you been treated by another doctor since the accident? ( ) Yes ( ) No If yes, please list the doctor's name and address: _____

What type of treatment did you receive? _____