PERSONAL INJURY QUESTIONNAIRE

NAME: _____ Date of Accident_____
Where did accident happen (Location) ? Describe the accident in your own words: Time of Accident _____

Weather conditions at the time of the accident, ex: dry, bright, sunny, wet, fog _____
Are you left or right handed? _____
How many passengers were 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
Your vehicle: Year _____ Make _____ Model _____ Your Speed _____
Other vehicle: Year _____ Make _____ Model _____ Their Speed _____
What direction was your car headed □ West □ East □ South □ North
What direction was the other car headed □ West □ East □ South □ North
Angles of impact… First Collision: □ Front □ Back □ Left □ Right
If Second Collision: □ Front □ Back □ Left □ Right
Accident Type □ Rear Ended □ Head On □ Broad Sided
Damage to your car: _____
Damage to other car: _____
Were you wearing a seat belt? □ Yes □ No
Were you under the influence of drugs or alcohol? □ Yes □ No
Females: Were you pregnant at time of accident? □ Yes □ No
Did you see collision coming □ Yes □ No
If yes, did you…….… step on the brake □ ……let off the brake □ ……other □
If other, please explain
_____
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
What position were your vehicle head rests in? □ lowest □ middle □ highest
What position was your body in just prior to the impact? □ straight □ rotated left □ rotated right □ can't remember
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 _____

Symptoms immediately following the accident: (ex: any pains, blurry vision, motor loss, paresthesia)
_____

_____

_____

Symptoms later that day: (ex: neck pain, shoulder pain, blurry vision, motor loss, paresthesia)

_____

_____

_____

Symptoms the day after the accident: (ex: any pain, headache, insomnia, inability to concentrate, motor loss, paresthesia)

_____

_____

_____

Were police called to the scene of the accident? □ Yes □ No

If so, do you have a copy of the police report? □ Yes □ No

Did you go to 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 a Orthopedic Surgeon ☐instructed to call a private physician

☐referred to this office for treatment ☐ Other _____

_____

….what were your diagnosed injuries?

_____

_____

_____

Have you seen any other doctor as a result of this accident? □ Yes □ No

For what?_____

_____

_____

Doctor's name

Current CHIEF Complaints or Symptoms: **Name:** **Date:**

☐**Neck pain** check off the areas that the pain runs into from the neck	☐none ☐left shoulder ☐left arm ☐left forearm ☐left hand ☐right shoulder ☐right arm ☐right forearm ☐right hand
☐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** select the areas of radiation, if any...	☐none ☐buttocks ☐left buttock ☐left thigh ☐left knee ☐left foot ☐right buttock ☐right thigh ☐right knee ☐right foot

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 at time of accident: _____
Current 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.) _____
How would you describe your health prior to the accident? (Example, excellent, good, poor) _____
What types of exercise were you able to perform prior to the accident and how often?_____
_____
_____
_____
_____

What types of activities were you able to do prior to the accident that you are unable to do now?
(inc.activities of daily living) _____
_____
_____
_____
_____

Do you have any pre-existing conditions that were aggravated by the accident? _____
_____
_____
_____

INSURANCE/ATTORNEY INFORMATION:

Your Insurance Company: _____Name of Agent: _____
Ins. Co. Address:_____City_____ St_____ Zip ____
Ins.Co. Phone: _____ Agent's Phone: _____
Claim Number _____

Other party Insurance Company: _____Name of Agent: _____
Ins. Co. Address:_____City_____ St_____ Zip ____
Ins.Co. Phone: _____ Agent's Phone: _____
Claim Number _____

Have you retained an Attorney? □ Yes □ No
Your Attorney's Name: _____ Phone # _____
Attorney's Address: _____
Were there any Witnesses? □ Yes □ No Name(s) _____