Personal Injury Questionnaire

Name_____ Date_____
Your Auto Insurance Co._____ Policy/Claim No._____
Agent's Name_____ Phone No._____
Name on Policy (if other than self)_____
Ins. Co. Address, City, State, Zip Code_____

Other Party Involved
Name_____
Insurance Company_____
Address_____ Phone No._____
City_____ State_____ Zip_____

Attorney
Name_____ Phone No. _____
Address_____
City_____ State_____ Zip_____

Nature of Accident

1.) Date of Accident_____ Time of Day_____
2.) City of Accident_____ State_____
3.) Number of people in your vehicle_____
Were you wearing seat belts?_____
4.) Were you the ❑Driver ❑Passenger, Front Seat ❑Passenger, Back Seat
5.) In which direction were you headed? ❑North ❑South ❑West ❑East
On (name of street)_____
6.) In which direction was the other vehicle headed? ❑N. ❑S. ❑W. ❑E.
7.) Were you struck from the ❑Rear ❑Front ❑Left Side ❑Right Side
8.) Road conditions at the time of accident: ❑Wet ❑Dry ❑Icy ❑Other
9.) Approximate speed of you car _____mph.
10.) Were the police notified? ❑Yes ❑No
11.) Were there any witnesses? ❑Yes ❑No
If yes, please list names:_____
12.) Were you taken to the hospital? ❑Yes ❑No
Name of Hospital_____
13.) In what city?_____
How did you get there?_____
14.) In your own words, please describe the accident:_____
_____
_____
15.) Did you have any physical complaints before the accident?_____
_____
16.) Please describe how you felt:
A. Immediately after the accident:_____
B. Later that day:_____
C. The next day:_____

Personal Injury Questionnaire

Check Symptoms You Have Noticed Since the Accident

( ) Headache
( ) Neck Pain
( ) Neck Stiff
( ) Sleeping Problems
( ) Back Pain
( ) Nervousness
( ) Tension
( ) Numbness in Toes
( ) Shortness of Breath
( ) Fatigue
( ) Depression
( ) Lights Bother Eyes
( ) Loss of Memory
( ) Ears Ting
( ) Feet Cold
( ) Stomach Upset
( ) Cold Sweats
( ) _____

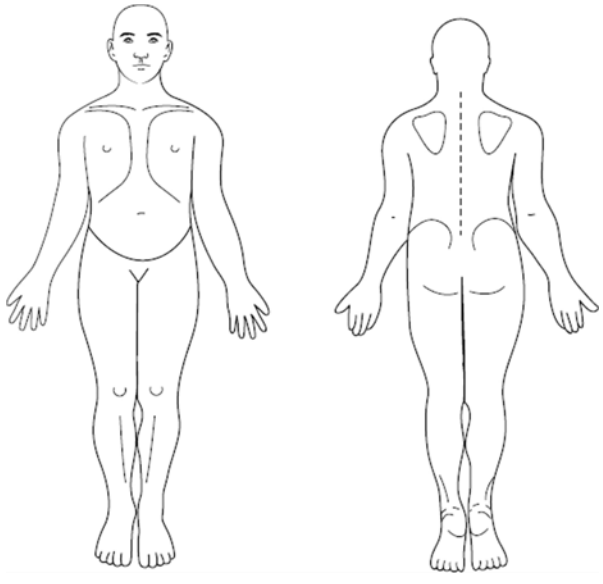
( ) Irritability
( ) Chest Pain
( ) Dizziness
( ) Head Seems Too Heavy
( ) Pins & Needles in Arms
( ) Pins & Needles in Legs
( ) Numbness in Fingers
( ) Face Flushed
( ) Buzzing in Ears
( ) Loss of Balance
( ) Fainting
( ) Loss of Smell
( ) Loss of Taste
( ) Diarrhea
( ) Hands Cold
( ) Constipation
( ) Fever

On the drawing below, please indicate where you are experiencing pain by drawing in the letter abbreviations on the diagrams that most accurately reflect the type of discomfort that you have been experiencing.

N= Numbness
P= Sharp Pain
T= Tingling
B= Burning
D= Dull Pain
S= Stiffness

PLEASE MARK ALL AREAS OF PAIN

BE SPECIFIC



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Personal Injury Questionnaire

17.) Have you had any other serious accidents which required medical care?
❑ No ❑Yes, describe:_____
18.) Have you had any serious illnesses that required hospitalization?
❑ No ❑Yes, describe:_____
19.) Have you had any surgeries?
❑No ❑Yes, list type of surgery and date_____
_____
20.) Have you returned to work since the accident? ❑No ❑Yes

The following questions pertain to you and the vehicle you were in:

1.) Were you ❑aware of the approaching collision prior to impact, or
❑did the impact catch you by surprise?
2.) How far is the top of the headrest or seat back from the top of your head?
(Approximately)_____inches above/below.
3.) Vehicle Year _____ Make _____ Model_____
4.) Was your car moving at the time of impact? ❑No ❑Yes, approx._____mph
5.) If moving, was it ❑slowing down or ❑gaining speed at the time of impact?
6.) What bleeding cuts did you get during this accident?_____
_____
7.)What bruises did you get during this accident?_____
_____
8.) On what part of the auto did the following body parts hit?
A. Head hit:_____
B. Chest hit:_____
C. Rt./Lt. Shoulder hit:_____
D. Rt./Lt. Arm hit:_____
E. Rt./Lt. Hip hit:_____
F. Rt./Lt. Knee hit:_____
G. Rt./Lt. Leg hit:_____
H. Other:_____
9.) What is the cost damage to the vehicle you were in?_____
10.) What of the following car parts broke during the accident?

_____Windshield	_____Front Seat/Back
_____Rt./Lt. Side Window	_____Other
_____Steering Wheel	_____Other

11.) Was the trunk of your body pointed straight forward at the time of the collision?
❑ Yes ❑No, it was turned to the ❑Left ❑ Right by how much?_____

The following questions pertain to the *other* vehicle involved in the accident:

1.) Other vehicle: Year_____ Make_____ Model_____
2.) Was the other vehicle moving at the time of the collision ❑No ❑Yes, at
approximately _____ mph.
3.) If the other vehicle was moving at the time of the collision, was it:
❑slowing down ❑gaining speed or ❑traveling at a steady speed?_____