

# PERSONAL INJURY QUESTIONNAIRE

Name \_\_\_\_\_ Date and time of accident \_\_\_\_\_

Where did accident happen? \_\_\_\_\_

Describe the accident \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Make and model of your vehicle \_\_\_\_\_ Other vehicle \_\_\_\_\_

**Road conditions:**

Wet  Dry

Icy

Other \_\_\_\_\_

What was your position in car?

Driver  Right front

Left rear  Right rear

Your vehicle was:

Stopped at time of impact

Accelerating

Slowing down

At steady speed

Did your vehicle strike other vehicle(s)?

Yes  No

Was your vehicle struck by other vehicle(s)?

Yes  No

Estimated speed of your vehicle

\_\_\_\_\_ MPH

Other vehicle

\_\_\_\_\_ MPH

Was the impact from the:

Front  Right side

Left side  Rear

Did your vehicle roll?

Yes  No

Multiple times?

Yes  No

At time of impact, were you looking:

Straight  Right

Left

Were both hands on steering wheel?

Yes  No

Was your foot on brake?

Yes  No

Were you braced for impact?

Yes  No

Were you wearing a :

Lap belt  Shoulder harness

Are there headrests on seat?

Yes  No

How far is top of headrest or seat back from top of head?

\_\_\_\_\_ inches

Where in the car were you after the accident? \_\_\_\_\_

Did you strike anything in vehicle at time of impact?

Yes  No

If yes, please specify:

Steering wheel  Dashboard

Windshield  Door

Arm rests  Side Window

Other \_\_\_\_\_

Please state part of body struck:

Chest  Chin

Knee  Shoulder

Hand  Head

Other \_\_\_\_\_

What bleeding cut(s) did you receive in the accident?

What bruise(s) did you receive in the accident?

Were you unconscious?

Yes  No

In a daze?

Yes  No

Did you go to the hospital?

Yes  No

If yes, when?

How did you get to the hospital?

Ambulance  Private Trans.

Did attendants place you in:

Brace  Splints

Neck collar

Were you X-rayed at the hospital?

Yes  No

Name of hospital: \_\_\_\_\_

Attended by doctor named: \_\_\_\_\_

How long did you stay? \_\_\_\_\_

What treatment was rendered? \_\_\_\_\_

**Please check symptoms you have noticed since the accident:**

Headache

Low back stiffness

Irritability

Constipation

Stomach upset

Head pain

Hip pain stiffness

Chest Pain

Loss of taste

Loss of smell

Neck pain

Nervousness

Dizziness

Arthritis

Fever

Neck soreness

Tension

Head seems too heavy

Numbness in toes

Knee pain

Neck stiffness

Neuritis

Pins & needles in arms

Pins & needles of feet

Leg cramps

Sleeping problems

Face Flushed

Arm pain

Shortness of breath

Shoulder pain

Hands cold

Loss of arm strength

Fatigue

Shoulder stiffness

Loss of hand strength

Buttock pain

Depression

Shoulder tension

Pins & Needles of hands

Pins & needles in legs

Lights bother eyes

Mid back pain

Loss of grip

Numbness in fingers

Loss of memory

Mid back tension

Fainting

Digestive disorders

Ears ring

Pain in ribs

Cold sweats

Feet cold

Anemia

Low back pain

Diarrhea

Loss of balance

Buzzing in ears

Is your pain:

- Constant
  - Sharp
  - Other \_\_\_\_\_
  - On and off
  - Dull
- Presently, pain is increased when you:
- Sit
  - Push
  - Walk
  - Crawl
  - Strain
  - Sneeze
  - Reach above shoulders
  - Rise from sitting
  - Kneel
  - Pull
  - Bend
  - Lift
  - Lift repeatedly
  - Cough
  - Crouch
  - Move bowels
  - Rise from bending

Is it difficult to move around in bed?

Yes  No

Have you had any change in your bowel habits?

Yes  No

Your most comfortable position:

- Sitting
- Standing
- Lying on right side
- Lying on left side
- Lying on back
- Lying on stomach

Have you ever been in an accident before?  Yes  No

If yes, please describe:

Date

Brief Description

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

What previous physical complaints if any did you experience immediately prior to this accident? Describe: \_\_\_\_\_

Were any of these complaints aggravated or made worse by the accident?  Yes  No

If yes, describe: \_\_\_\_\_

### OCCUPATIONAL INFORMATION

What is your occupation? \_\_\_\_\_ How long? \_\_\_\_\_

Name of employer? \_\_\_\_\_

Have you lost any time from work because of this accident?

Yes  No

If yes, give dates of time lost. From \_\_\_\_\_ To \_\_\_\_\_

Totally disabled from \_\_\_\_\_ to \_\_\_\_\_

Partially disabled from \_\_\_\_\_ to \_\_\_\_\_

Are you now limited in your lifting ability in some body position that you were previously not?

Yes  No

What symptoms does lifting produce: \_\_\_\_\_

How long do these symptoms last? \_\_\_\_\_

What positions can you work in with a MINIMUM DEMAND of physical effort?

Standing  Walking

Sitting

With Minimum Demand of physical effort, what positions can you work in PART-TIME and for how long?

Standing \_\_\_\_\_

Walking \_\_\_\_\_

Sitting \_\_\_\_\_

With Minimum Demand of physical effort, can you work in a SITTING POSITION with some degree of walking or standing activity?

Yes  No

Do you feel that you cannot perform any physical work activity?

Yes  No

Do you feel that you cannot perform any mental work?

Yes  No

Generally speaking, is your inability to perform these functions due to:

Pain  Weakness

Nerves  Structural limitations

Any sexual impairment since accident?

Yes  No

Are you able to take care of your personal self, such as dressing, bathing, etc?

Yes  No

Or do you require assistance?

Yes  No

Do you feel your present condition is temporary?

Yes  No

Or permanent?

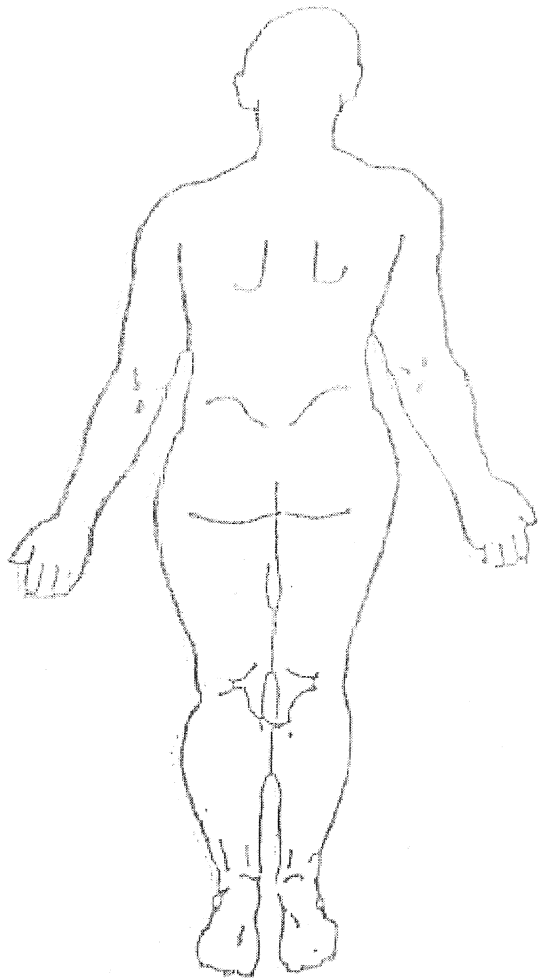
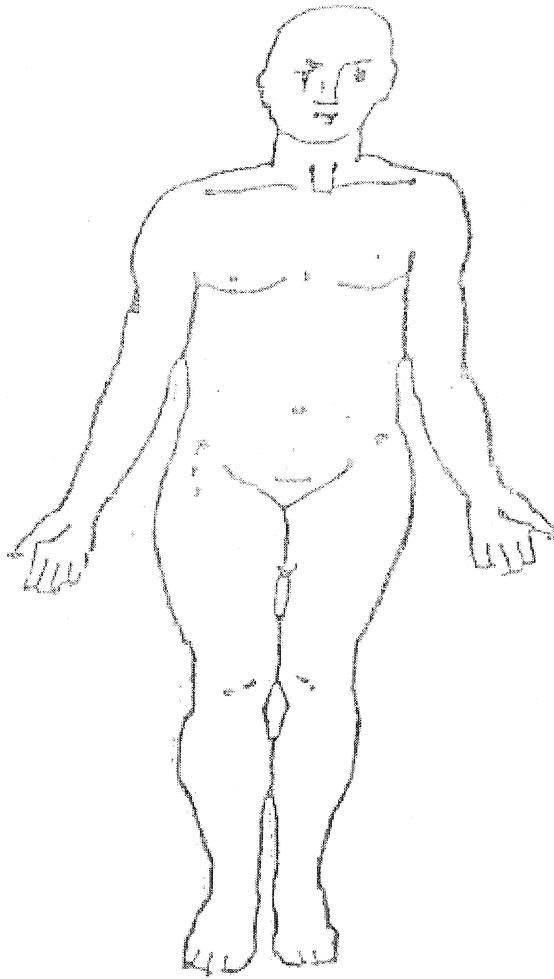
Yes  No

Signed

Name \_\_\_\_\_ Date \_\_\_\_\_

Please fill this out accurately. Use no symbols except those indicated. Mark the areas on your body where you feel the described sensation. Use the appropriate symbol. Mark areas of radiation. Include all affected areas.

Numbness +++      Burning Pain 000      Sharp, Stabbing Pain ///      Aching Pain (((



RATE YOUR PAIN:

	0 = No Pain					10 = Extremely Intense Pain					
1. Right Now	0	1	2	3	4	5	6	7	8	9	10
2. At its Worst	0	1	2	3	4	5	6	7	8	9	10
3. At its Best	0	1	2	3	4	5	6	7	8	9	10

**AUTO ACCIDENT INSURANCE INFORMATION**

DO YOU HAE **MED-PAY BENEFITS FROM YOUR CAR INSURANCE?** If so, complete the following:

Insurance Company \_\_\_\_\_

Mailing Address \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Police Holder \_\_\_\_\_  
Claim Number \_\_\_\_\_

DO YOU HAVE A **GENERAL HEALTH INSURANCE POLICY THAT WILL COVER YOUR ACCIDENT CLAIM?** Some general health insurance companies will deny benefits if an auto insurance carrier is primarily responsible for your medical bills. If you have a plan that will cover your claims, please complete the following:

Insurance Company \_\_\_\_\_

Mailing Address \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Insured Name \_\_\_\_\_  
Insured's SS# \_\_\_\_\_  
Group Number \_\_\_\_\_

DO YOU HAVE AN **ATTORNEY TO REPRESENT YOU FOR THIS ACCIDENT?** If so, complete the following:

Attorney \_\_\_\_\_

Mailing Address \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**IT IS IMPORTANT THAT THIS INFORMATION BE FILLED OUT ACCURATELY AND COMPLETELY. THIS WILL HELP YOU OBTAIN BENEFITS PROMPTLY.**