PERSONAL INJURY QUESTIONNAIRE

Please be thorough when completing this form. If the inquiry does not apply write N/A

First Name Middle Name Surname — Date: Month Day Year

Our Insurance Company — Agent's Name

Name on Policy (if other than self) — Policy Number

Name of Responsible Party in Accident — Phone: Area Code + Number

Address: Street * City * State * Zip Code

Policy Holder's Name (If different) — Policy Number

Name of Attorney — Phone: Area Code + Number

Address Street * City * State * Zip Code

NATURE OF ACCIDENT

Date of Accident: Month * Day * Year * Time of Day — Were There any Witnesses? /____/ No /____/ Yes (please list names above)

1. You were the: /____/ Driver /____/ Passenger /____/ Front Seat /____/ Back Seat
2. Number of people in your vehicle /____/ Were you wearing seat belts? /____/ No /____/ Yes
3. Which direction were you headed? (Circle One) N S E W On what street?__________________________________
4. What direction was the other vehicle headed? (Circle One) N S E W
5. You were struck from: /____/ behind /____/ front /____/ left side /____/ right side
6. Approximate speed you were traveling? ___________mph Approximate speed of the other car? ______________mph
7. Were you knocked unconscious? /____/ No /____/ Yes If yes, for how long? ____________________________________
8. Were the police notified? /____/ No /____/ Yes

In your own words, please describe the accident: ____

Did you have any physical symptoms before the accident? /____/ No /____/ Yes If yes, please describe: ______________________

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Please describe how you felt:

During the accident ____

Immediately after the accident ____

Later that day: ____

The next day: ____

____

What are your present complaints and symptoms?

____

Do you have any congenital (from birth) factors which relate to this case? /____/ No /____/ Yes

____

Have you ever been in an accident before? /____/ No /____/ Yes (please describe)

____

Where were you taken after the accident?

____

Have you been treated by another doctor since this accident? /____/ No /____/ Yes (please list doctor's names)

____

What type of treatment did you receive?

Since this injury occurred, your symptoms are: /____/ Improving /____/ Getting Worse /____/ The Same

PLEASE CHECK THE SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT

____ Headache	____ Chest Pain	____ Shortness of Breath	____ Face Flushes	____ Feet Cold
____ Neck Pain	____ Dizziness	____ Irritability	____ Buzzing in Ears	____ Hands Cold
____ Neck Stiffness	____ Head Seems too Heavy	____ Fatigue	____ Loss of Balance	____ Stomach Upset
____ Sleeping Problems	____ Pins & Needles in Arms	____ Depression	____ Fainting	____ Constipation
____ Back Pain	____ Pins & Needles in Legs	____ Lights Bother Eyes	____ Loss of Smell	____ Cold Sweats
____ Nervousness	____ Numbness in Fingers	____ Loss of Memory	____ Loss of Taste	____ Fever
____ Tension	____ Numbness in Toes	____ Ears Ring	____ Diarrhea	____ List Other

____

List any symptoms other than above.

Have you lost time from work as a result of this accident? /____/ No /____/ Yes (please complete)

1. Last Day Worked: ____
2. Type of Employment: ____
3. Present Salary ____
4. Are you being compensated for lost time from work? /____/ No /____/ Yes If yes, please state the type of compensation

   you are receiving: ____

____

Do you notice any activity restrictions as a result of this injury? (Please describe)

____

____

Signature Date