PERSONAL INJURY QUESTIONNAIRE

PATIENT INFORMATION

Name: ____ Date: ______________________
Date of Birth: ___________________ Height: ____________ Weight: _________ Dominant Hand? R L
Address: ____City: ________________ State: _______
Zip: ____________ Phone (cell): ______________________ Phone (other): ______________________
DL#:________________________ E-mail: ____

INSURANCE INFORMATION

It is our policy to collect all pertinent information for your file. With your consent, all insurance billing will be taken care of by this office, after a full discussion of your case with the Doctor.

Your car insurance:
Name: ____________________________Address:____
City: _______________ State: ______ Zip:_____________ Policy #:_______________ Med Pay?: Y N
Amount ($): _____________ Adjuster ___________________ Phone #:_________________ Ext. ______
Claim #:______________ Insured: _____________________ Date of Loss/Accident: ________________

Your health insurance:
Name: _______________________________________ Member ID: ______________________
Group #:_______________ Primary insured: _____________________ SS#: ________________
DOB of primary: ______________ Provider phone # (on back of card): _______________________

3rd party (their car insurance):
Name: _____________________________ Address: ____
City: ____________________ State: ______ Zip: ______________________
Insured:_______________________________ Adjuster _________________ Claim #_________________
Phone #: _______________________ Ext. _________

Attorney (if applicable):
Name: ______________________________________ Law Firm: ____________________________________
Phone #: _______________________ Ext: _________ Fax #: _____________________________
Address: ____ City: ________________________
State: ______ Zip:___________

Additional Information:
Cost of all medical treatment since the accident? $: __________________
How much income have you lost since the accident? $: _____________________
What is the property damage (repair amount) of your car? $: _________________

Name of your personal M.D.: _____________________________ Phone: ________________________
Address: _______________________________________City/State:_____________ Zip: _______________
Write any Ambulance, Hospital, M.D., Chiropractor, Acupuncturist, PT, etc., you have been to since the accident:

Name	Type	Phone #	Amt. of Bill	Records Rec'd
_______________________	_____	______________	______________	YES NO
_______________________	_____	______________	______________	YES NO
_______________________	_____	______________	______________	YES NO
_______________________	_____	______________	______________	YES NO

INFORMATION ABOUT YOUR ACCIDENT

1. Date of Accident: _________________________
2. Were you: ( ) Driver ( ) Passenger ( ) Front Seat ( ) Back Seat
3. Number of people in your vehicle: ___________
4. What direction were you headed? ( ) North ( ) South ( ) East ( ) West
5. What direction was the other vehicle headed? ( ) North ( ) South ( ) East ( ) West
6. Were you struck from: ( ) Behind ( ) Front ( ) Left side ( ) Right side
7. Approximate speed of your car: _______
8. Were you knocked unconscious? ( ) Yes ( ) No
9. Were the police notified? ( ) Yes ( ) No
10. Do you have a copy of the police report? ( ) Yes ( ) No ( ) N/A
11. In your own words, please describe the accident:

____

____

____

12. Did you have any physical complaints BEFORE the accident? ( ) Yes ( ) No
*If yes, describe:

____

____

13. Please describe how you felt:
   A. DURING the accident: ____
   B. IMMEDIATELY AFTER the accident: ____
   C. LATER that day: ____
   D. The NEXT day: ____

14. What are your PRESENT complaints and symptoms?

____

____

15. Do you have any congenital (from birth) factors which relate to this problem?

____

____

16. Do you have previous illnesses which relate to this case? ( ) Yes ( ) No
*If yes, please describe:

____

____

17. Have you ever been involved in an accident before? ( ) Yes ( ) No
*If yes please describe, including date(s) and type (s) of accidents as well as injuries received:

____

____

18. Since the injury occurred, are your symptoms ( ) Improving ( ) Getting worse ( ) Same
19. CHECK SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT:

( ) HEADACHE ( ) IRRITABILITY ( ) NUMBNESS-TOES ( ) FACE FLUSHED ( ) FEET COLD ( ) NECK PAIN
( ) CHEST PAIN ( ) SHORTNESS OF BREATH ( ) BUZZING IN EARS ( ) HANDS COLD ( ) NECK STIFFNESS
( ) DIZZINESS ( ) FATIGUE ( ) LOSS OF BALANCE ( ) STOMACH UPSET ( ) PROBLEM SLEEPING ( ) HEAVY HEAD
( ) DEPRESSION ( ) FAINTING ( ) CONSTIPATION ( ) BACK PAIN ( ) PINS/NEEDLES ARMS ( ) LIGHT SENSITIVE EYES
( ) LOSS OF SMELL ( ) COLD SWEATS ( ) NERVOUSNESS ( ) PINS/NEEDLES LEGS ( ) LOSS OF MEMORY ( ) LOSS OF TASTE ( ) FEVER ( ) TENSION ( ) NUMBNESS-FINGER ( ) EARS RING ( ) DIARRHEA ( ) OTHER: _________________

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20. Have you lost time from work as a result of this accident? ( ) Yes ( ) No
a. Last day worked: ____________________
b. Type of employment: __________________________________
c. Present Salary: __________________
d. Are you being compensated for time lost from work? ( ) Yes ( ) No
*If yes, type of compensation you are receiving: ____
21. Do you notice any activity restrictions as a result of this injury? ( ) Yes ( ) No
22. Other pertinent information:
____
____
____