PERSONAL INJURY QUESTIONAIRE

INFORMATION ABOUT YOU

Name_____DOB:_____/_____/_____
AGE:_____ Sex: ( )M ( ) F SSN_____-_____-_____
Address:_____ Phone:_____Alt. Phone:_____
_____ _____ _____ Email:_____
(city) (state) (zipcode)

Emergency Contact Name:_____
Phone:_____ Relationship:_____
Employer: _____ Work Phone:_____

Responsible Parties Name:_____
Insurance Company:_____
Claim Number: _____
Adjusters Name:_____Adjusters Phone Number:_____

Your Auto Insurance Company:_____
Name on policy (if other than self):_____
Policy Number:_____Claim Number:_____
Adjusters Name:_____Adjusters Phone Number:_____

INFORMATION ABOUT YOUR ATTORNEY

Name_____ Phone:_____FAX#:_____
Address:_____
_____ _____ _____
(city) (state) (zipcode)

INFORMATION ABOUT YOUR ACCIDENT

1. Date of Accident _____ Time of Day _____
2. Name the city, state, and street were the accident occurred:_____
3. Were there any witnesses? ( )Yes ( )No Names _____
4. Were the Police notified? ( )Yes, Report Number:_____ ( )No,Why:_____
5.Do you have Pictures of the damage to your vehicle ( )Yes ( )No
6. Estimated Damage:$_____ Was the vehicle totaled? ( )Yes ( )No

ADDITIONAL DETAILS ABOUT THE ACCIDENT

7. Were You: ( )Driver ( )Passenger ( )Front Seat ( )Back Seat
8. Number of people in your vehicle? _____ Where you wearing seat belts? ( )Yes ( )No
9. What direction were you headed? ( )North ( )East ( )South ( )West
Approximate speed of your car _____ MPH
10. What Direction was the other vehicle headed? ( )North ( )East ( )South ( )West
Approximate speed of their vehicle _____ MPH
11. Were you struck from: ( )Behind ( )Front(head-on) ( )Left Side ( )Right Side
12. Were you knocked unconscious? ( )Y ( )N If yes, for how long?_____
13. In your own words, please describe the accident: _____

_____

_____

Staff_____ INP____PIC____PIM____ PIM/L_____ PIL_____

Name:_____Date:_____

14. Please Describe how you felt:
    a. DURING the accident: _____

    b. IMMEDIATELY AFTER the accident _____

    c. LATER THAT DAY: _____

    d. THE NEXT DAY: _____

15. Where were you taken after the accident? _____

16. Have you been treated by another doctor since the accident? ( )Yes ( )No
    If yes, names:
_____

17. What are your PRESENT complaints and symptoms?

CHECK SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT:

( ) HEADACHE	( ) IRRITABILITY	( ) NUMBNESS-TOES	( ) FACE FLUSHED	( ) FEET COLD
( ) NECK PAIN	( ) CHEST PAIN	( ) SHORTNESS-BREATH	( ) BUZZING IN EARS	( ) HANDS COLD
( ) NECK STIFF	( ) DIZZINESS	( ) FATIGUE	( ) LOSS OF BALANCE	( ) STOMACH UPSET
( ) SLEEPING PROBLEMS	( ) HEAD IS HEAVY	( ) 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-FINGERS	( ) EARS RING	( ) DIARRHEA	( ) _OTHER

Describe Other: _____

_____

_____

18. Since this injury occurred, are symptoms ( )Improving ( )Getting Worse ( )Same

19. 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: _____

20. Do you notice any activity restrictions as a result of this injury? ( )Yes ( )No
    If yes, please describe: _____

OTHER PERTINENT INFORMATION

21. Did you have any physical complaints BEFORE THE ACCIDENT? ( )Yes ( )No
    If yes, Describe_____

22. Do you have any congenital (from birth) factors which relate to this problem?
    If yes, Describe _____

23. Do you have any previous illness which relate to this case? ( )Yes ( )No
    If yes, please Describe: _____
    _____

24. 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 a injuries received:

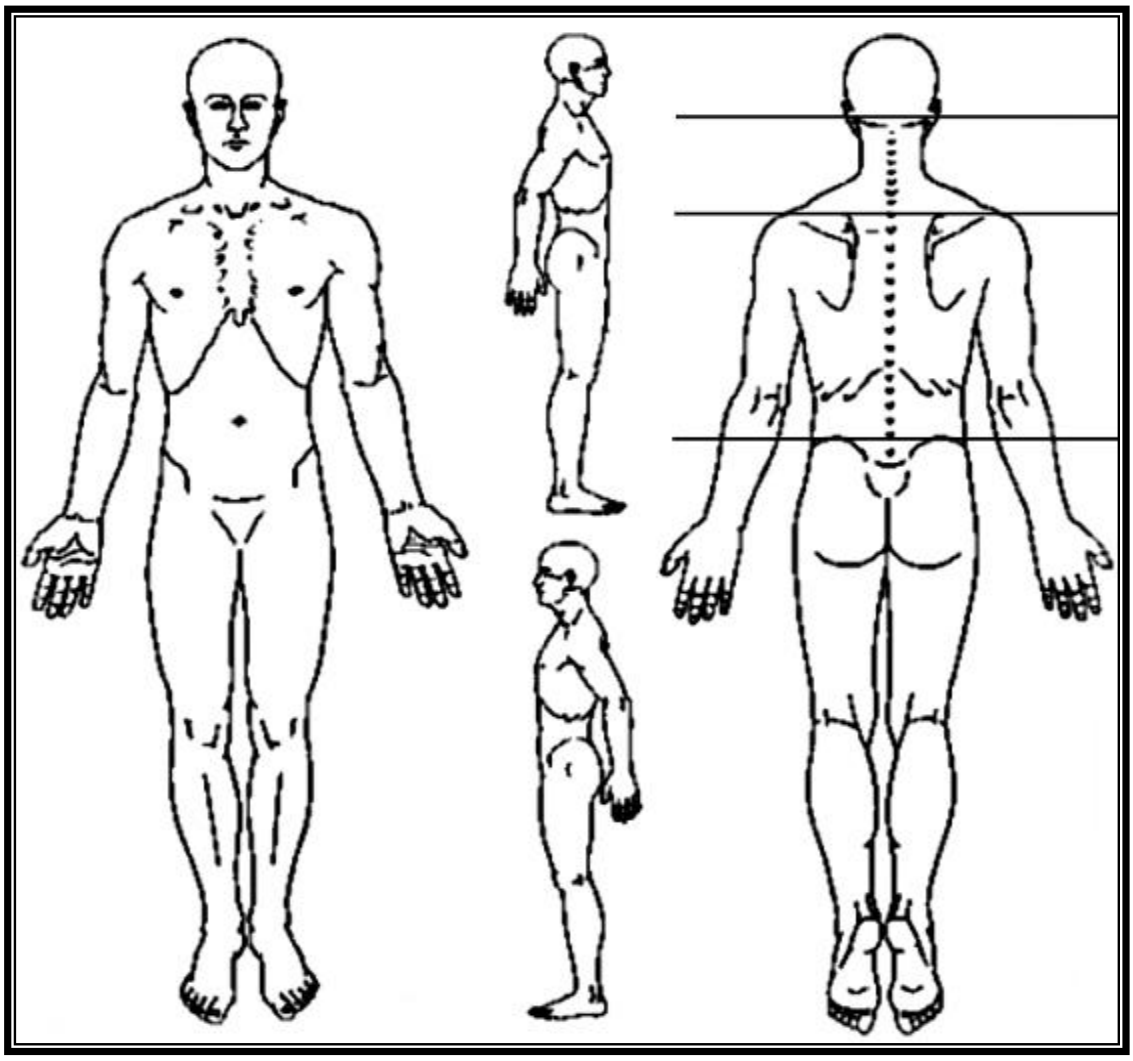
    _____
    _____

Staff_____

Name:_____Date:_____

How long have you had this pain: _____years _____months _____weeks
On the diagram below, please indicate where you are experiencing pain or other symptoms, right now. (use multiple sheets for more than one area)

Use the pain scale below the diagram, to indicate how severe your discomfort is or has been.
1=Feeling Great ~ 10=Worst pain imaginable



1	2	3	4	5	6	7	8	9	10	Level of discomfort right now
1	2	3	4	5	6	7	8	9	10	Best it has felt in the past week (or since the last form)
1	2	3	4	5	6	7	8	9	10	Worst it has felt in the past week (or since the last form)

_____ _____

Patient Signature Date

Staff_____