Personal Injury Questionnaire *(Please answer all questions completely)*

Today's Date_____

Name_____ Date of Birth_____ Age_____
Address_____ City_____ State____ Zip_____
Home Phone_____ Cell Phone_____
Occupation_____ Employer_____ Work Phone _____
E mail: _____

Date of Accident_____ Time_____am / pm Location_____
Please explain in detail how your accident happened_____
_____
Did you go to a Hospital or Emergency Room? Yes No Name_____
Have you lost days from work? Yes No Dates_____
What is your major complaint? _____
How is your condition changing? GETTING BETTER GETTING WORSE NOT CHANGING

Circle symptoms you have noticed since the accident: (circle all that apply)

Headache	Irritability	Tension	Neck Pain	Chest Pain	Diarrhea
Buzzing in Ears	Face Flushed	Neck Stiff	Dizziness	Fatigue	Depression
Ears Ring	Fever	Back Pain	Cold Sweats	Head Seems Heavy	
Shortness of Breath	Pins & Needles in Legs	Numbness in Toes	Loss of Memory		
Loss of Taste	Sleeping problems	Light Bothers Eyes	Fainting Spells		
Loss of Balance	Numbness in Fingers	Nervousness			

Symptoms other than above_____

If Automobile Accident

Were you: (circle one) Driver Front seat passenger Back seat passenger Pedestrian
Were you struck from: Behind Right side Left Side Front Auto was parked
Road Condition: Damp Dry Icy Snow Covered Wet Fog
Speed of your automobile _____ Speed of other automobile _____
Were seat belts worn by you? Yes No What position was your headrest? _____

Name and address of Ins. Co. where bills are to be sent_____
_____
Claim/File Number (obtain from insurance company)_____
Insurance Company Phone Number_____ Contact Person_____
Name and Address of Attorney (if you have retained one)_____
_____ Phone Number_____

I authorize the release of any information necessary to process the claim regarding the accident listed above.

_____ _____ _____
Patient's Name (Printed) Patient's *Signature* Date
(If a minor, parent or guardian signature)

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