PERSONAL INJURY QUESTIONNAIRE

PATIENT INFORMATION:

Name:_____ ID#:_____ Date:_____

ATTORNY INFORMATION:

Name:_____ Phone:_____

Were there any witnesses? No Yes Name(s) _____

Phone:_____

NATURE OF ACCIDENT:

1. Date of Accident: _____ Time: _____ am pm
2. Road Conditions: Dry Damp Wet Raining Icy Snowing Snow Covered
3. Number of people in your vehicle? _____
4. In your words, please describe the accident: _____

_____

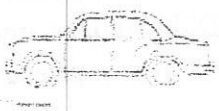
_____

_____

5. You were the: Driver Front-seat Passenger Back-seat passenger (Left Middle Right)
6. Were you wearing a seatbelt? No Yes
7. Did you have a Shoulder harness restraint AND OR Lap Belt Restraint
8. Did the airbag deploy? No Yes
9. What type of vehicle were you driving/riding in? Car Truck Van SUV Motorcycle Bus
10. The other vehicle involved was a? Car Truck Van SUV Motorcycle Bus
11. How many vehicles were involved in the accident? _____ Circle Position (1st, 2nd, 3rd...) of your vehicle







12. Which direction were you traveling? North East South West
    On (name of street)? _____
13. Which direction was the other vehicle traveling? North East South West
    On (name of street? _____
14. Your vehicle was struck from? Behind Front Left-Side Right- Side
15. The approximate speed of your car was _____ mph, and the other car was _____ mph.
16. Was your foot on the brake? No Yes N/A
17. Did you see the accident coming? No Yes N/A
18. Upon impact, you were looking: Straight ahead Left Right Back
19. Upon impact, your body jolted: Forward Backward Left Right N/A
20. Upon impact were you reaching for anything? No Yes, Explain: _____
21. Upon impact did your head hit anything? No Yes, What? _____
22. Did you hit any other part of your body? No Yes, Which part? _____
23. Did you lose consciousness? No Yes, For how long? _____
24. Did anything hit you, move, or break inside the car upon impact? No Yes, What? _____
25. Were police notified? No Yes, Was anyone cited? No Yes Unknown

Dr. Initials: _____

Patient Name: _____ Date: _____

26. Where did you go after the accident? Home Hospital Urgent Care Other? _____
27. Did you go immediately to the hospital? No Yes
28. How did you get there? Your Car Another Car, with whom? _____ Ambulance
29. What is the name of the hospital? N/A Hospital: _____

TREATMENT RECEIVED

30. Have you seen any other doctor(s) since the accident? No Yes
    Emergency Room Doctor (Name, if known): _____
    Primary Car Physician (Name, if known): _____
    Other: _____
31. On which date did you receive treatment? Same day Next day Other _____
32. Did you receive treatment/examination in a hospital? No Yes, which one? _____
33. Which of the following were performed? X-Rays CT Scan MRI N/A
    To Which Regions? Head Neck Mid-Back Low-Back Other: _____
34. What type of treatment did you receive? _____
35. Was medication prescribed? No Yes, What? _____

SYMPTOMS

36. When did you begin to experience pain, soreness, stiffness, etc.?
    Immediately after accident Later the same day Next Day Other: _____
37. Since this injury occurred, your symptoms have: Improved Gotten Worse Remained the Same
38. Do you have any congenital (from birth) factors which relate to this problem? No Yes
    If yes, please describe: _____
39. Did you have any physical complaints before the accident? No Yes
    If yes, please describe in detail. _____
40. Have you lost time from work as a result of this accident? No Yes
    If yes, please complete the following:
    Last day worked: _____ Type of Employment: _____
41. Do you notice any restrictions in your activity as a result of this injury? No Yes
    If yes, please describe in detail: _____

Patient Signature: _____ Date: _____
or Legal Guardian if patient is a minor.

Dr. Signature: _____ Date: _____
NOTES: _____