## PERSONAL INJURY QUESTIONNAIRE

Name			11/2	_ Phone (	)	
Address						
Age Birthdate		Sex	S/S#			
Employer's Name		_ Employer's Add	ress		· ·	
Your Ins. Co	Policy #	<del>,</del>	Agent's	Name		-
Name on Policy (If other than self)				_ Policy#		<u> </u>
Responsible Party's Name						
Address		_ City		_ State	7	Zip
Policy Holder's Name				_ Policy#		
ATTORNEY	1					
Name				_ Phone (	) _	65 (39)
Address		_ City		_ State	:	Zip
Were there any witnesses? ( ) Yes	s ( ) No Name(s)					
NATURE OF ACCIDENT:					ь,	
Date of Accident	Time of Day					
2. Were you: ( ) Driver (	) Passenger ( ) Fr	ont Seat ( ) B	ack Seat			
3. Number of people in your vehicle	e? Were you w	earing seat belts?				117
What direction were you heade     on (name of street)						***************************************
What direction was other vehice on (name of street)	le headed? ( ) Nor	th ( ) East	( ) South		*	eall
6. Were you struck from: ( )	Behind ( ) Front	( ) Left side	( ) Right	side		2*
7. Approximate speed of your car	mph Other ca	ar mph				
8. Were you knocked unconscious		No If yes, for ho	ow long?			
9. Were police notified? ( ) Y						
10. In your own words, please descri			E			
3						
11. Did you have any physical comp	olaints BEFORE THE AC			o If yes, pl	ease de	escribe in detail
	t .					
12. Please describe how you felt:		Ŷ				
a. DURING the accident:						
b. IMMEDIATELY AFTER the ac	ccident:					
c. LATER THAT DAY:						
d. THE NEXT DAY:						

3.	What are your PRESENT complaints and symptoms?
4.	Do you have any congenital (from birth) factors which relate to this problem? ( ) Yes ( ) No If yes, please describe
5.	Do you have any previous illnesses which relate to this case? ( ) Yes ( ) No If yes, please describe:
6.	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 injury(ies) received.
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8.	Where were you taken after the accident?
9.	Since this injury occurred, are your symptoms: ( ) Improving ( ) Getting Worse ( ) Same
0.	CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT:    Headache
	Symptoms Other Than Above
1.	Have you lost time from work as a result of this accident? ( ) Yes ( ) No If yes, please complete this question
	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, please state type of compensation
	you are receiving:
22.	Do you notice any activity restrictions as a result of this injury? ( ) Yes ( ) No If yes, please describe, in detail
23. (	Other pertinent information:
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	PATIENT'S SIGNATURE