PERSONAL INJURY QUESTIONNAIRE

Name ______________________________ Date of Accident ____________ Time ____________

Where did the accident happen? ______________________________
Describe the accident in your own words ______________________________
____
____

List the year, make and model of the vehicle you were in:
year ____________ make ____________ model ____________
What is the year, make and model of the other vehicle?
year ____________ make ____________ model ____________

What was your position in the car? _____ Driver _____ Passenger
If passenger, were you seated in: _____ Front _____ Rt. Rear ____ Lt. Rear
Did you strike the other vehicle? _____ Yes _____ No
Was your vehicle struck by the other vehicle? _____ Yes ______ No
Impact was from: _______ the front _______ right side _____ left side _____ rear
At the time of the impact you were _____ looking straight ahead ______looking right _______ looking left
Were both hands on the steering wheel? _____ Yes ______ No Was your foot on brake? ______ Yes _____ No
Did you strike anything in the vehicle at time of impact? ____ Yes _____ No
If yes, please specify:
____ steering wheel ____ dashboard ____ windshield ____ side door ____ arm rests ____ side window ____head rest

Please state the body part:
_____ chest _____ face _____ hip _____ knee _____ shoulder _____ hand _____ head

Were you wearing a seat belt? ______ Yes _____ No

Immediately following the accident how did you feel? ______________________________
____

Did you become
CONFUSED DISORIENTED LIGHTHEADED DIZZY BLURRED VISION RING/BUZZ IN EARS NAUSEATED

Were you unconscious? _____ Yes _____ No In a daze? _____ Yes _____ No
Did you go to the hospital? _____ Yes _____ No
When? ______________________________
How did you get to the hospital? _____ ambulance _____ private transportation
Were you placed in a: ____ neck collar _____ splints ______ brace
Name of the hospital ______________________________ Attended by Dr. ____________________
Were you X-rayed at the hospital? _____ Yes _____ No
What was the diagnosis? ______________________________
Were you admitted to the hospital? _____ Yes _____ No How long did you stay? ____________________
What treatment was rendered? ______________________________
Have you seen any other doctor as a result of this accident? _____ Yes _____ No

Doctor's Name ______________________________

FOR OFFICE USE ONLY

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