

PERSONAL INJURY QUESTIONNAIRE

NAME: _____ Today's Date ____/____/____ Date of Accident ____/____/____

Where did accident happen? Describe the accident in your own words:

What type of vehicle were you in? Car Truck Van Bus Other _____

What was your position in the vehicle?

Driver: if Driver were your hands on the steering wheel? Left Right Both

Passenger: If passenger, were you sitting in Front Rear Passenger side Rear Driver's Side

Did your vehicle strike another vehicle? Yes No

Was your vehicle struck by another vehicle? Yes No Type of Vehicle (**other vehicle**): _____

Speed of your vehicle: Stopped Slowing Slowly moving Moving at approximately ____mph.

Angles of impact... Front Driver's side impact Rear-end Collision

Front Passenger's side impact Head-on Collision Pedestrian Collision

Were you wearing a seat belt? Yes No

Did Airbags deploy? Yes No

Did you brace for impact? Yes No ... I braced with my hands I braced with my feet

Which way were you facing at the time of impact... straight ahead Left Right

What were the conditions at the time of the accident: dry damp wet/rain snow covered ice covered

What was the time of day? full daylight dawn dusk night

Did you strike anything in vehicle at time of impact? Yes No

If yes, specify what part of your body struck what: ie... head chest chin shoulder Right / Left Knee

Steering Wheel _____ Dashboard _____

Windshield _____ Roof _____

Left Side Door _____ Right Side Door _____

Left Side Window. _____ Right Window _____

Other _____

Did the seat back bend / break ? Yes No

Immediately following the accident, how did you feel? dizzy/dazed disoriented unconscious

nervous nauseous upset weak Other _____

Did you go to hospital? Yes No Were you admitted to the hospital? Yes No if yes how long? _____

If you went to hospital, when? At time of accident Next day

How did you get to hospital? Ambulance Police Car Private Transportation

Name of Hospital: _____

Attended by Dr. _____

What treatment was given?

none placed in a cervical collar x-rayed given stitches Bandaged

given pain medication given instructions regarding concussions

given instructions regarding sprains and strains Physical Therapy

instructed to call a Orthopedic Surgeon instructed to call a private physician

referred to this office for treatment Other _____

Was your vehicle damaged? Yes No Approximate amount under \$1000 \$1000-\$5000 Totaled

Have you seen any other doctor or health care provider as a result of this accident? Yes No

Doctor/ provider's name: _____

CHIEF Complaints or Symptoms:

<input type="checkbox"/> Neck pain check off the areas that the pain runs into from the neck	<input type="checkbox"/> none	<input type="checkbox"/> left shoulder	<input type="checkbox"/> left arm	<input type="checkbox"/> left forearm	<input type="checkbox"/> left hand	<input type="checkbox"/> right shoulder	<input type="checkbox"/> right arm	<input type="checkbox"/> right forearm	<input type="checkbox"/> right hand
<input type="checkbox"/> Headache									
<input type="checkbox"/> Migraine Headache									
<input type="checkbox"/> Upper back pain									

Ringling in Ears Yes No Left Right Both Ears

Blurry Vision Yes No Left Right Both Eyes

Wrist Pain Yes No Left Right Both Wrists

Jaw Pain Yes No Left Right Both Sides

Dizziness nervousness fatigue anxiety depression excessive irritability

fear of driving in a car a loss of concentration jaw clenching grinding of teeth at night nightmares

difficulty with sleeping at night

<input type="checkbox"/> Low Back Pain select the areas of radiation, if any...	<input type="checkbox"/> none	<input type="checkbox"/> buttocks	<input type="checkbox"/> left buttock	<input type="checkbox"/> left thigh	<input type="checkbox"/> left knee	<input type="checkbox"/> left foot	<input type="checkbox"/> right buttock	<input type="checkbox"/> right thigh	<input type="checkbox"/> right knee	<input type="checkbox"/> right foot
---	-------------------------------	-----------------------------------	---------------------------------------	-------------------------------------	------------------------------------	------------------------------------	--	--------------------------------------	-------------------------------------	-------------------------------------

Hip Pain	<input type="checkbox"/> Left	<input type="checkbox"/> Right	<input type="checkbox"/> Bilateral
Knee Pain	<input type="checkbox"/> Left	<input type="checkbox"/> Right	<input type="checkbox"/> Bilateral
Foot Pain	<input type="checkbox"/> Left	<input type="checkbox"/> Right	<input type="checkbox"/> Bilateral

Numbness:

Left Hand Left Upper Arm Right Hand Right Upper Arm

Left Foot Left Leg Right Foot Right Leg

Additional Symptoms/ Complaints:

Have you lost any time from work due to your injuries? Yes No

If yes please give dates: _____

Type of employment: _____

Have you had previous injuries or accidents? Yes No

Description of previous Accident: _____

Description of previous injuries: _____

Is there any residual pain from the previous injury? Yes No