PERSONAL INJURY QUESTIONNAIRE

Today’s Date: __________________

Name: ___________________________________ Date of Accident: ________________

Your Ins. Co & Policy #:_________________________ Agent’s Name & #: __________________

Your Ins. PIP Claim#:___________________________ Adjuster’s Name & #: _________________

Driver / Other Vehicle: ________________ Ins. Co. & Policy #: ________________________

NATURE OF ACCIDENT

You were the: Driver ☐ Front Passenger ☐ Rear Driver ☐ Rear Passenger ☐ Pedestrian ☐

# of people in the vehicle: ______ # of people in the other vehicle: ______

Collision: Rear-End ☐ Side: Left ☐ Right ☐ Head-On ☐ Parked ☐ Other: _________________

Road condition: Dry ☐ Wet ☐ Icy ☐ Road Surface: Asphalt ☐ Gravel ☐ Dirt ☐

Your vehicle: Compact ☐ Mid – size ☐ Truck ☐ SUV ☐ Other: _________________________

Other vehicle: Compact ☐ Mid – size ☐ Truck ☐ SUV ☐ Other: _________________________

Your speed at the time of accident: Estimate ________________ mph

Body Position at time of impact: Facing straight ahead ☐ Head turned ☐ Right ☐ Left ☐

Does your vehicle have a headrest? Yes ☐ No ☐ If yes, approximately how far was the top of
the headrest from the top of your head? ________________ Above ☐ Below ☐

Were you wearing a seatbelt? No ☐ Yes ☐ Lap ☐ Shoulder ☐ Lap and Shoulder ☐

Any bruising or soreness from the seat belt? No ☐ Yes ☐ Explain __________________________

Did your vehicle strike another car? Yes ☐ No ☐

Did your vehicle strike another object? Yes ☐ No ☐

Were you aware of the approaching collision prior to impact? Yes ☐ No ☐

Condition of your vehicle after impact: Drivable ☐ Totaled ☐

Police report issued? Yes ☐ No ☐ Traffic violation issued? Yes ☐ No ☐

Brief explanation of accident: _______________________________________________________

________________________________________________________________________________

________________________________________________________________________________

NATURE OF INJURY

Injuries occurred at time of accident: _____________________________________________

________________________________________________________________________________

________________________________________________________________________________

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Did you receive first aid at the scene of the accident?  Yes ☐ No ☐ N/A ☐

Did you receive any medical care following the accident?   Yes ☐ No ☐

If yes, where were you treated, when were you treated and by whom?

What type of treatment did you receive?

Did you have any physical complaints BEFORE THE ACCIDENT?   Yes ☐ No ☐

If yes, describe in detail

What are your PRESENT complaints and symptoms?

Parts of the body struck: ___________________________________________

Since this injury occurred, are your symptoms:  Improving ☐ Getting Worse ☐ Same ☐

CHECK SYMPTOMS THAT YOU HAVE NOTICED SINCE ACCIDENT:

( ) Headache ( ) Neck Pain ( ) Neck Stiffness ( ) Upper-back Pain ( ) Mid-back Pain

( ) Low-back Pain ( ) Hip Pain ( ) Knee Pain ( ) Loss of Balance ( ) Shoulder Pain ( ) Elbow Pain

( ) Wrist Pain ( ) Arm Pain ( ) Leg Pain ( ) Chest Pain ( ) Dizziness ( ) Fainting ( ) Fever ( ) Diarrhea

( ) Constipation ( ) Fatigue ( ) Foot Pain ( ) Irritability ( ) Sleeping Problems ( ) Shortness of Breath

( ) Pins & Needles in Arms ( ) Pins & Needles in Legs ( ) Loss of Memory ( ) Ears Ringing

( ) Numbness in Fingers ( ) Numbness in Toes ( ) Face Flushed ( ) Cold Sweats ( ) Depression

( ) Nervousness ( ) Cold Feet ( ) Cold Hands ( ) Light sensitivity

Symptoms other than above: ___________________________________________

Other Pertinent information: ___________________________________________

I attest that all of the information I have given is truthful and accurate to the best of my ability.

Patient’s Signature: __________________________________________ Date: ________________