PERSONAL INJURY QUESTIONNAIRE

(FORM UPDATED 05/23/2020)

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 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 ☐

Did airbags deploy? If so, which ones? Driver ☐ Passenger ☐ Left Side ☐ Right Side ☐

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: _____

_____

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:** _____