PERSONAL INJURY QUESTIONAIRE

Complete Name _____Telephone ( ) _____ Cell Phone ( ) _____

Complete Address _____ City _____ State _____ Zip _____

Age _____ Birth date _____ Gender _____ S/S _____ Marital Status _____

Employer's Name _____ Employer Phone ( ) _____ Occupation _____

Employer's Complete Address _____ City _____ State _____ Zip _____

Your Car Ins. Co. _____ Policy # _____ Agent's Name _____

Policy Holder's Name _____ Claim # _____ Adjuster's Name _____

ATTORNEY

Name _____ Phone ( ) _____

Complete Address _____ City _____ State _____ Zip_____

Were there any witnesses ( ) Yes ( ) No Names(s) _____

NATURE OF ACCIDENT

1. Date of Accident _____ Time of Day _____
2. Were you: ( ) Driver ( ) Passenger ( ) Front Seat ( ) Back Seat

3. Number of people in your vehicle? _____ Were you wearing seat belt(s)? _____
4. What direction were you headed? ( ) North ( ) East ( ) South ( ) West On (what street) _____
5. What direction was the other vehicle headed? ( ) North ( ) East ( ) South ( ) West
6. Were you struck ( ) Behind ( ) Front ( ) Left Side ( ) Right Side

7. Approximate speed of your car _____mph Other car _____mph
8. Were you knocked unconscious? ( ) Yes ( ) No If yes, how long? _____
9. Were the police notified? ( ) Yes ( ) No
10. In your own words, please describe the accident: _____

_____

_____

_____

11. Did you have any physical complaints BEFORE THE ACCIDENT? ( ) Yes ( ) No If yes, please describe in detail

_____

_____

12. Please describe how you felt:
    a. DURING the accident: _____

    b. IMEDIATELY AFTER the accident: _____

    c. LATER THAT DAY: _____

    d. THE NEXT DAY: _____

13. What are your PRESENT complaints and symptoms? _____

_____

14. Do you have any illnesses which relate to this accident? ( ) Yes ( ) No If yes, please describe:

_____

15. Where were taken, if anywhere, after the accident? _____
16. Have you been treated by another doctor since the accident? ( ) Yes ( ) No If yes, please list doctor's name(s)

and address: _____

17. What type of treatment did you receive? And what type of results did you get? _____
18. Since this accident occurred, are your symptoms: ( ) Improving ( ) Getting Worse ( ) Same

19. CIRLE SYMPTOMS YOU HAVE NOTICE SINCE THE ACCIDENT:

Headache	Irritability	Numbness in Toes	Face Flushed	Feet Cold
Neck Pain	Chest Pain	Shortness of Breath	Buzzing in Ears	Hands Cold
Neck Stiff	Dizziness	Fatigue	Loss of Balance	Stomach Upset
Sleeping Problems	Head Seems to Heavy	Depression	Fainting	Constipation
Back Pain	Pins & Needles in Arms	Lights Bother Eyes	Loss of Smell	Cold Sweats
Nervousness	Pins & Needles in Legs	Loss of Memory	Loss of Taste	Fever
Tension	Numbness in Fingers	Ears Ring	Diarrhea	_____

20. Have you lost time from work as a result of this accident? ( ) Yes ( ) No If yes, how long? _____

21. Do you notice any activity restrictions as a result of this injury? ( ) Yes ( ) No If yes, please describe, in detail:

_____

_____

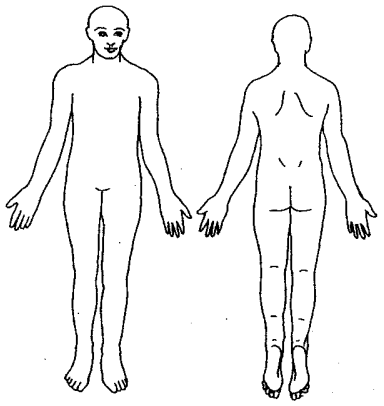
_____

22. Have you ever been involved in an accident before? ( ) Yes ( ) No If yes, please describe, in detail:
Including dates and treatment received: _____

_____

_____

23. Please mark area(s) affected by the accident on the body.



_____ _____ _____

DATE PATIENT'S NAME (PLEASE PRINT) PATIENT'S SIGNATURE