

PERSONAL INJURY QUESTIONNAIRE

Name: _____ Phone: () _____
Address: _____ City: _____ State: _____ Zip: _____
Age: _____ Date of Birth: _____ Sex: _____ S/S #: _____
Employer's Name: _____ Employer's Address: _____
Your Ins. Co.: _____ Policy: _____ Agent's Name: _____
Name on Policy(if other than self): _____ Policy: _____
Responsible Party's Name: _____ Policy: _____
Address: _____ City: _____ State: _____ Zip: _____

ATTORNEY INFO:

Name: _____ Phone: () _____
Address: _____ City: _____ State: _____ Zip: _____
Were there any witnesses? No Yes Name(s): _____

NATURE OF ACCIDENT:

1: Date of Accident: _____ Time of Day: _____ Weather Conditions: _____
2: Were you: Driver Passenger Front Seat Back Seat
3: Were you wearing a seatbelt: NO YES lap belt shoulder belt No. of people in vehicle: _____
4: What was the height of your head rest: _____ Did your head hit the head rest: NO YES
5: Did you hit your head? NO YES Did you hit any other part of body? NO YES
6: What direction were you headed: North South East West Name of Street: _____
7: What direction was other vehicle headed: North South East West Name of Street: _____
8: Were you struck from: Front Behind Left side Right side
9: Approximate speed of your car: _____ mph Other car(approx.): _____ mph
10: Were you knocked unconscious? No Yes Can't recall If yes, for how long? _____
11: Were the police notified? No Yes
12: Did an ambulance attend to you at the scene of the accident? NO YES If yes, please describe in detail:

A: Were you transported to a hospital? NO YES
B: Was a wheelchair used? NO YES
C: A Body Board? NO YES
D: Neck Immobilized? NO YES

13: In your own words, please describe accident: _____

14: Did you have any physical complaints BEFORE THE ACCIDENT: NO YES If yes, please describe in detail:

15: Please describe how you felt:
A: DURING THE ACCIDENT: _____
B: IMMEDIATELY AFTER the accident: _____
C: LATER THAT DAY: _____
D: THE NEXT DAY: _____

16: Did you have any bruising or lacerations? NO YES If yes, please describe in detail:

