Personal Injury Questionnaire

1. Name: ______________________________ Age:_________ Sex: ☐ Male ☐ Female
2. Phone Number:_______________________ Date of Birthday:_________________________
3. Date of Accident: ______________________ Time of Day: ____________________________
4. Condition of weather: ☐ Clear/Dry ☐ Rainy/Wet ☐ Windy/Cloudy
5. Place of Accident: ☐ Eastbound ☐ Westbound ☐ Northbound ☐ Southbound of _______________________

   Nearest Cross-Street: ____
6. Nature of Accident: ☐ Rear-End ☐ T-bone ☐ Head-on ☐ Slip-and-Fall ☐ Dog-Bite
7. Were you: ☐ Driver ☐ Front Seat ☐ Back Seat (Behind Driver) ☐ Back Seat (Behind Front Passenger)
8. How many people were in your vehicle (including yourself): __________________________
9. Approximate speed of: Your car ________mph Other Car _________mph
10. What was the estimated damage of your vehicle? $_______________ ☐ Don't know ☐ Total Loss
11. What was the model and year of your car? How about the other's car?

    Your Car: Year_________ Maker______________ Model__________ The Other Car_________________
12. Were you wearing seat belts? ☐ Yes ☐ No Did airbag deploy? ☐ Yes ☐ No ☐ No airbag equipped
13. Did any part of your body collide in the car? ☐ Yes ☐ No

    If yes, explain how and where ____
14. Were you knocked unconscious? ☐ Yes ☐ No If yes, for how long?________________________
15. Who came to the scene of accident? ☐ Police/CHP ☐ Paramedics/Ambulance ☐ Fire Department
16. Was a formal traffic/collision report obtained by the law enforcement? ☐ Yes ☐ No
17. In your own words, please describe the accident: ____________________________________

    ____

    ____

    ____

    Please describe how you felt

    a. IMMEDIATELY AFTER the accident: ____
    b. LATER THAT DAY and NEXT DAY: ____
18. Did you have any physical complaints BEFORE THE ACCIDENT? ☐ Yes ☐ No

    If so, please describe what body part: ____
19. Have you ever been involved in any kind of accident before, including personal injury/worker's compensation injury?

    ☐ Yes ☐ No

    If yes, please describe including date(s) and type(s) of accident, as well as injury(ies) received: ___________

    ____
20. Were you taken to hospital by ambulance? ☐ Yes ☐ No ☐ Ambulance/paramedics did not arrive

    Did you drive to Emergency Department since the accident? ☐ Yes ☐ No

    If yes, which hospital?:________________________________in city of________________________

(continued)

If yes, what did they do for you there? ☐ X-rays ☐ CT Scan ☐ Medications:____________________________

☐ Other:____

Were you released from Emergency Department on same day? ☐ Yes ☐ No

If not, how many days were you admitted in Hospital? ________________________

Have you been treated by another doctor/urgent care since the accident? ☐ Yes ☐ No

If yes, list: Urgent Care / Doctor's Name:_____________________________ Telephone: _____________________
Address: ______________________________________ City:________________ State:_____ Zip:____________

If yes, list: Urgent Care / Doctor's Name:_____________________________ Telephone: ____________________
Address: ______________________________________ City:________________ State:_____ Zip:____________

21. Since this injury occurred, are your symptoms ☐ improving ☐ getting worse ☐ same

22. Do you notice any activity restrictions as a result of this injury? ☐ Yes ☐ No

If yes, please describe in detail (e.g. bending/stooping, grooming, washing dishes, vacuuming, golfing, etc.):
____
____
____

23. Present Complaints:

A:____

Pain Scale (1 = No Pain, 10 = Severe Pain): _______

B:____

Pain Scale (1 = No Pain, 10 = Severe Pain): _______

C:____

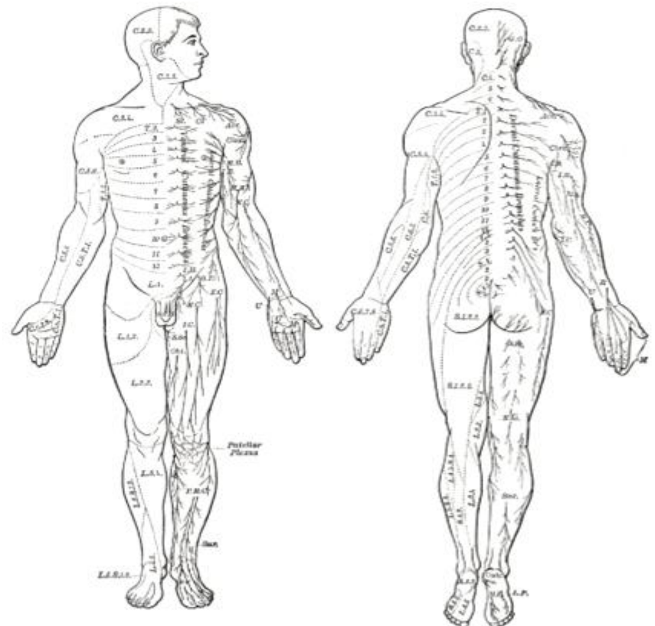
Pain Scale (1 = No Pain, 10 = Severe Pain): _______

D:____

Pain Scale (1 = No Pain, 10 = Severe Pain): _______

F:____

Pain Scale (1 = No Pain, 10 = Severe Pain): _______



Circle the area of pain

DATE:______________________ PATIENT'S SIGNATURE:____