

## PERSONAL INJURY QUESTIONNAIRE

Name: \_\_\_\_\_ Date of Accident: \_\_\_\_\_

Where did the accident happen? Describe the accident in your own words:

What was your position in the car?

- Driver: If Driver were your hands on the steering wheel?  Left  Right  Both  
 Passenger: If passenger, were you sitting in  Front  Right Rear  Left Rear

Did your vehicle strike another vehicle  Yes  No

Was your vehicle struck by another vehicle  Yes  No

Angles of impact: First Collision:  Front  Back  Left  Right

If second collision:  Front  Back  Left  Right

Were you wearing a seat belt?  Yes  No

Did you brace for impact?  Yes  No ....  I braced with my hands  I braced with my feet

Which way were you facing at the time of impact ...  straight ahead  Left  Right

Did you strike anything in the vehicle at the time of impact?  Yes  No

If yes, specify what part of your body struck what: ie ... head chest chin shoulder right/left knee

- Steering Wheel  Dashboard  Windshield  Roof  
 Left Side Door  Left Side Window  
 Right Side Door  Right Window  
 Other: \_\_\_\_\_

Did the seat back bend / break?  Yes  No

Immediately following the accident, how did you feel?  dizzy/dazed  disoriented  unconscious  
 nervous  nauseous  upset  weak  other: \_\_\_\_\_

Did you go to the hospital?  Yes  No

Were you admitted to the hospital?  Yes, for how long? \_\_\_\_\_  No

How did you get to the hospital?  Ambulance  Police Car  Private Transportation

Name of hospital: \_\_\_\_\_

Attended by Dr. \_\_\_\_\_

- Treatment given:  none  placed in cervical collar  x-rayed  given stitches  bandaged  
 given pain medication  given instructions regarding concussions  physical therapy  
 given instructions regarding sprains and strains  instructed to call an Orthopedic Surgeon  
 instructed to call a private physician  referred to this office for treatment  
 Other: \_\_\_\_\_

Have you seen any other doctor because of this accident?  Yes  No

Doctor's names: \_\_\_\_\_

Chief complaints or symptoms: Name \_\_\_\_\_ Date: \_\_\_\_\_

<input type="checkbox"/> Neck Pain: check off the areas that pain runs from the neck
<input type="checkbox"/> None
<input type="checkbox"/> Left shoulder <input type="checkbox"/> left arm <input type="checkbox"/> left forearm <input type="checkbox"/> left hand
<input type="checkbox"/> Right shoulder <input type="checkbox"/> right arm <input type="checkbox"/> right forearm <input type="checkbox"/> right hand
<input type="checkbox"/> Headache
<input type="checkbox"/> Migraine
<input type="checkbox"/> Upper back pain

Ringing in ears:  Yes  No  Left  Right  Both ears

Blurry vision:  Yes  No  Left  Right  Both eyes

Wrist pain:  Yes  No  Left  Right  Both wrists

Jaw pain:  Yes  No  Left  Right  Both sides

Dizziness  Depression  Nightmares  Nervousness  Jaw Clenching  Anxiety

Fatigue  Excessive irritability  Grinding of teeth at night  difficulty sleeping at night

Fear of driving in a car  A loss of concentration  Other: \_\_\_\_\_

Low back pain: select the areas of radiation, if any

None

Buttocks  left buttock  left thigh  left knee  left foot

Right buttock  right thigh  right knee  right foot

Hip pain:  Left  Right  Bilateral

Knee pain:  Left  Right  Bilateral

Foot pain:  Left  Right  Bilateral

Additional symptoms/complaints: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have you lost any time from work due to your injuries?  Yes  No

If yes, please give dates: \_\_\_\_\_

Type of employment: \_\_\_\_\_

Have you had previous injuries or accidents?  Yes  No

Description of previous accident: \_\_\_\_\_

\_\_\_\_\_

Description of previous injuries: \_\_\_\_\_

\_\_\_\_\_

Is there any residual pain from the previous injury?  Yes  No

How much better did you feel prior to your current condition? (Example 100%, 80%, etc.) \_\_\_\_\_

\_\_\_\_\_