## PERSONAL INJURY QUESTIONAIRE

Date	
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When did the accident occur?								
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Were you the:	□Driver	□Passenger	□Other	Driven by ————				
Were you struck from	: □Behind	□Front	□Left Side	☐ Right Side				
What time of day:	□Day	□Night	□Dawn	□Dusk				
What was the road cond	lition like? □Dry	□Damp	□Wet	☐ Don't know or remember				
Was the head rest:	□In Place	□Tucked Down	□Not Sure					
Were you wearing a s	seatbelt? □Yes □N	0						
Did the seatbelt also I	have a shoulder harne	ess? □Yes □No						
How many hands did	you have on the steer	ring wheel? □One on w	wheel Two on wheel					
Just prior to the accid	ent, were you: □Looki	ing straight ahead DT	urned to the rightTurn	ned to the left				
Were the brakes appl	ied? □Yes □No							
Were you knocked un	conscious?	⊒No						
Did you know that the	accident was about to	o happen? □Yes □N	0					
Were you wearing gla	sses? □Yes □No							
Were the glasses still	on after impact? □Ye	es •No						
Were you struck by a	ny objects inside the o	ar? □Yes □No De	escribe					
		*						
	-		# H H H H H H H H H H H H H H H H H H H					
Was the car: ☐Tota	lled □Drivable	□Not drivable	□Towed □Not	Sure				
Check the symptoms	you have noticed sinc	e the accident:						
□Headache	□Blurred Vision	□Facial Numbness	□Suboccipital Pain	□Cervical Pain				
□Lower Cervical Pain	☐Shoulder Stiffness	□Elbow Pain	□Wrist & Hand pain	□Numbness In Hands				
□Finger Numbness	☐Mid Thoracic Pain	□Chest Pain	□Lumbar Pain	Dizziness				
□Facial Pain	□Facial Paralysis	□Upper Cervical Pain	□Cervical Stiffness	□Lower Cervical/Upper Thoracic Pain				
□Upper Arm Pain	□Lower Arm Pain	□Hand & Finger Pain	□Numbness In Hands & Fingers	s, DUpper Thoracic Pain				
□Abdominal Pain	□Lumbosacral Pain	□Saccrococcidial Pain	☐Leg Pain	☐Genital Area Pain				
□Lower Leg Pain	□Leg Cramping	□Numbness of Foot & Toes	☐Genreal Muscle Stiffness	□Nervousness				
□Tenitis	□Fatigue	□Loss Of Sleep	□Digestive Disorders	□Defacation Problems				
□Fever	□Coccyx Pain	Leg Numbness	☐Knee Pain	□Lower Leg Numbness				
□Ankle Pain	☐Cramping of Foot & Toes	☐General Joint Pain	□Tension	□Vision Irregularity				
Depression	☐Breathing Disorders	☐Bowel Disorder	☐Urination Problems	□Chills				

Have you ever had any complaints in the above areas prior to the accident? ☐Yes ☐No

Were you taken to the emergency room after the accident?   Yes   No								
What treatment was given?				dos un sus des ces				
What was the diagnosis?			4					
Was any other doctor consulted	d after the accident? If	yes, please give the doo	ctor's name, treatment	given, and how				
long you saw the doctor.		- 44 .745.0 027447	X 1007					
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