PERSONAL INJURY QUESTIONAIRE

Date ____________________

When did the accident occur? ____________________

Please explain in detail how your accident happened: ____________________

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 condition like? ❑Dry ❑Damp ❑Wet ❑ Don't know or remember

Was the head rest: ❑In Place ❑Tucked Down ❑Not Sure

Were you wearing a seatbelt? ❑Yes ❑No

Did the seatbelt also have a shoulder harness? ❑Yes ❑No

How many hands did you have on the steering wheel? ❑One on wheel ❑Two on wheel

Just prior to the accident, were you: ❑Looking straight ahead ❑Turned to the right ❑Turned to the left

Were the brakes applied? ❑Yes ❑No

Were you knocked unconscious? ❑Yes ❑No

Did you know that the accident was about to happen? ❑Yes ❑No

Were you wearing glasses? ❑Yes ❑No

Were the glasses still on after impact? ❑Yes ❑No

Were you struck by any objects inside the car? ❑Yes ❑No Describe ____________________

Was the car: ❑Totalled ❑Drivable ❑Not drivable ❑Towed ❑Not Sure

Check the symptoms you have noticed since 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	❑Upper 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? ___

What was the diagnosis? ___

Was any other doctor consulted after the accident? If yes, please give the doctor's name, treatment given, and how long you saw the doctor. ___

Additional Comments: ___