

PERSONAL INJURY QUESTIONNAIRE

PATIENT INFORMATION:

Name: _____ Address: _____
Apt. _____ City: _____ State: _____ Zip Code: _____
Sex: Male Female Home #: _____ Work #: _____
Cell #: _____ Pager #: _____ S.S. #: _____
Driver License: _____ State: _____ Date of Birth: _____

Single Married Widowed Separated Divorced

Employer: _____ Address: _____
City & State: _____ Zip Code: _____ Occupation: _____
How did you find out about us.(Name) _____
Nearest Relative: _____ Relation: _____
Phone #: _____

ATTORNEY:

Name: Law Offices of _____ Handling Case: _____
Phone #: _____ Fax #: _____ Address: _____ Ste. _____
City: _____ State: _____ Zip Code: _____

Were there any witnesses? Yes No Name(s) _____
These witnesses were they in your car? Yes No

ACCIDENT INFORMATION:

1. Date of Accident: _____ Time of Day: _____ am pm
Type of Accident: Rear Ended Ran into another Car other: _____
2. Were you the: Driver Passenger , Front Seat Back Seat
3. Number of people in your vehicle (including yourself)? _____
4. Were you wearing a seat belt? Yes - No
5. Were you struck from: Front Behind , Left Side Right Side
6. Approximate the speed of your car _____ mph. Other car _____ mph.
7. Were you knocked unconscious? Yes No
If yes, for how long? _____
8. Where were you taken after the accident? Home Work Hospital Friend/ Relative Home
Other _____
9. Have you seen another doctor besides Dr. Kirkpatrick? Yes No

If yes, please list:

Name: _____ Address: _____

Phone: _____

What type of treatment did you receive? _____

How many days and weeks were you treated? _____

Was medication prescribed? Yes No If yes, list name and for what? _____

10. Were police notified? Yes - No

11. In your own words, please describe the accident: _____

12. What are your PRESENT complaints and symptoms? _____

13. Since the injury occurred, are your symptoms: Improving Getting Worse Same

14. Check the symptom(s) you have noticed during and after the accident:

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Irritability | <input type="checkbox"/> Numbness in Toes | <input type="checkbox"/> Face Flashes |
| <input type="checkbox"/> Cold Feet | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Buzzing in Ears | <input type="checkbox"/> Cold Hands | <input type="checkbox"/> Stiff Neck | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Fainting | <input type="checkbox"/> Stomach Upset | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Head Seems Too Heavy | <input type="checkbox"/> Depression | <input type="checkbox"/> Ears Ring |
| <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Constipation | <input type="checkbox"/> Back Pain | <input type="checkbox"/> Cold Sweats |
| <input type="checkbox"/> Lights Bother Eyes | <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Loss of Taste |
| <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Pins & Needles in Legs | <input type="checkbox"/> Fever | <input type="checkbox"/> Tension |
| <input type="checkbox"/> Numbness in Fingers | | | |

Other symptoms not mention above, please list: _____

15. Have you lost time from work due to this accident? Yes - No

If yes, please list the last day you worked: _____

16. Do you notice any activity restrictions due to this accident? Yes - No

If yes, please describe, (What Type, When and For How Long): _____

17. Have you ever been involved in an accident before? Yes No

If yes, please list what type(s) of accident and when: _____

Date: _____

Patient Signature: _____
(If minor, parent signature)