PERSONAL INJURY QUESTIONAIRE

INFORMATION ABOUT YOU

Name _____ Phone _____
Address _____ City _____ State _____ Zip _____
Age_____ Birthdate _____ Sex ( )M ( )F S/S# _____
Employer's Name_____ Employer's Address _____
Your Ins. Co. _____ Policy# _____ Agent's Name _____
Name on Policy (if other than self) _____ Policy # _____
Responsible Party's Name _____
Address _____ City _____ State ___ Zip _____

INFORMATION ABOUT YOUR ATTORNEY

Name _____ Phone _____ Fax _____
Address _____ City _____ State ___ Zip _____
Were there any Witnesses? ( )Yes ( )No Names _____

INFORMATION ABOUT YOUR ACCIDENT

1. Date of Accident _____ Time of Day _____
2. Were You: ( )Driver ( )Passenger ( )Front Seat ( )Back Seat
3. Number of people in your vehicle? _____ Where you wearing seat belts? ( )Y ( )N
4. What direction were you headed? ( )North ( )East ( )South ( )West
5. What Direction was the other vehicle headed? ( )North ( )East ( )South ( )West
   on (name of street) _____
6. Were you struck from: ( )Behind ( )Front ( )Left Side ( )Right Side
7. Approximate speed of your car _____ MPH. Other car _____ MPH
8. Were you knocked unconscious? ( )Yes ( )No If yes, for how long? _____
9. Were Police Notified? ( )Yes ( )No
10. In your own words, please describe the accident: _____

_____

_____

11. Did You have any physical complaints BEFORE THE ACCIDENT? ( )Yes ( )No
If yes, Describe: _____

_____

_____

12. Please Describe how you felt:
    a. DURING the accident: _____

    b. IMMEDIATELY AFTER the accident _____

    c. LATER THAT DAY: _____

    d. THE NEXT DAY: _____

13. What are your PRESENT complaints and symptoms?

_____

_____

_____

14. Do you have any congenital (from birth) factors which relate to this problem?

_____

_____

15. Do you have any previous illness which relate to this case? ( )Yes ( )No
If yes, please Describe: _____

_____

16. Have you ever been involved in an accident before? ( )Yes ( )No
If yes, please describe, including date(s) and type(s) of accidents as well a injuries received:

_____

17. Where were you taken after the accident? _____

18. Have you been treated by another doctor since the accident? ( )Yes ( )No
If yes, names: _____

19. Since this injury occurred, are symptoms ( )Improving ( )Getting Worse ( )Same

20. CHECK SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT:

( ) HEADACHE	( ) IRRITABILITY	( ) NUMBNESS-TOES	( ) FACE FLUSHED	( ) FEET COLD
( ) NECK PAIN	( ) CHEST PAIN	( ) SHORTNESS-BREATH	( ) BUZZING IN EARS	( ) HANDS COLD
( ) NECK STIFF	( ) DIZZINESS	( ) FATIGUE	( ) LOSS OF BALANCE	( ) STOMACH UPSET
( ) SLEEPING PROBLEMS	( ) HEAD IS HEAVY	( ) DEPRESSION	( ) FAINTING	( ) CONSTIPATION
( ) BACK PAIN	( ) PINS/NEEDLES ARMS	( ) LIGHT SENSITIVE EYES	( ) LOSS OF SMELL	( ) COLD SWEATS
( ) NERVOUSNESS	( ) PINS/NEEDLES LEGS	( ) LOSS OF MEMORY	( ) LOSS OF TASTE	( ) FEVER
( ) TENSION	( ) NUMBNESS-FINGERS	( ) EARS RING	( ) DIARRHEA	( ) _____

Symptoms other than above _____

21. Have you lost time from work as a result of this accident? ( )Yes ( )No
a. Last day worked: _____
b. Type of employment: _____
c. Present Salary: _____
d. Are you being compensated for time lost from work? ( )Yes ( )No
If yes, type of compensation you are receiving: _____

22. Do you notice any activity restrictions as a result of this injury? ( )Yes ( )No
If yes, please describe: _____

_____

24. What is the total cost of property damage from this accident? _____

23. Other pertinent information: _____

_____

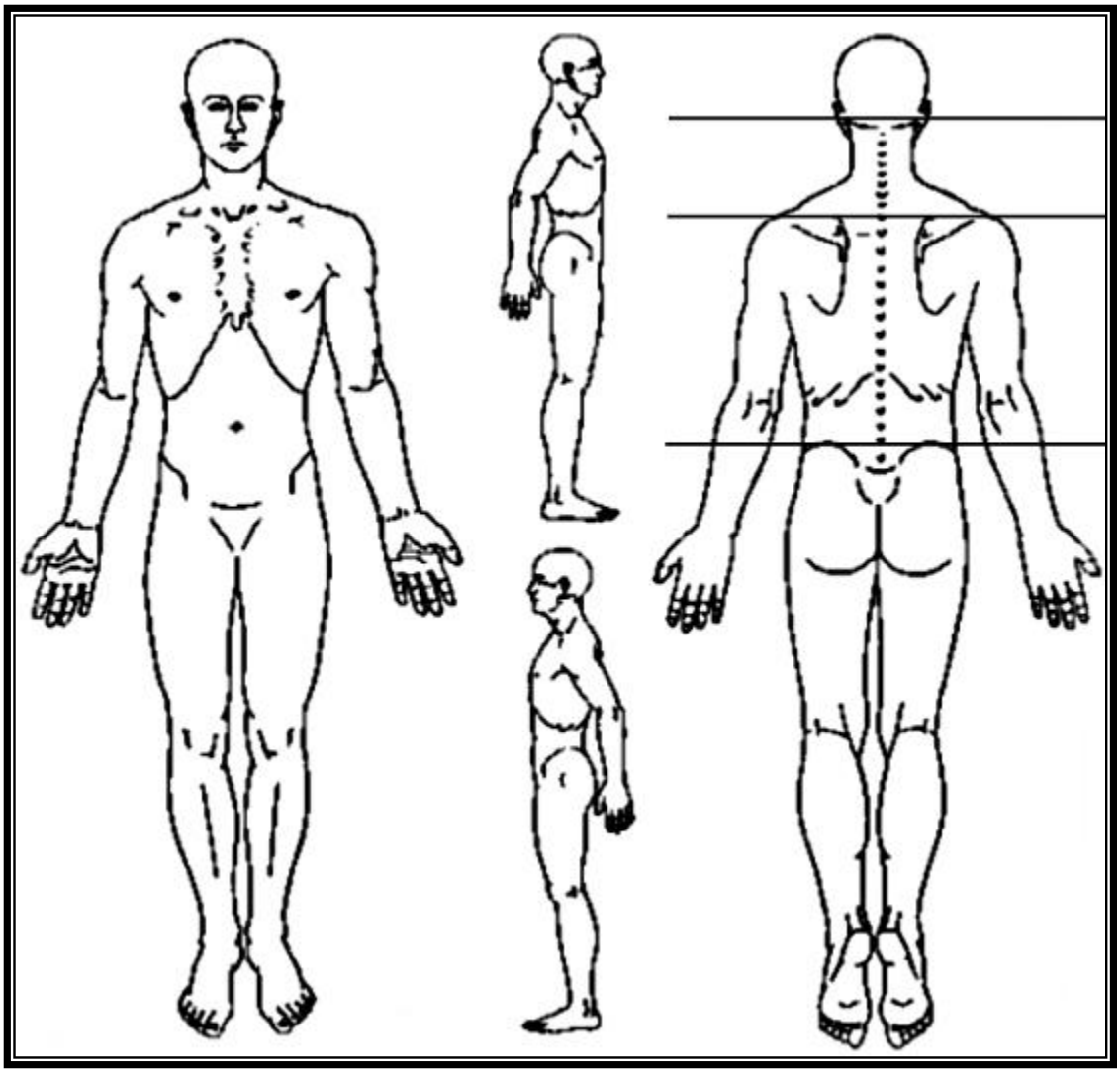
_____

_____ _____

Date Patient's Signature

Name _____ Date _____

How long have you had this pain: _____years _____months _____weeks
On the diagram below, please indicate where you are experiencing pain or other symptoms, right now. (use multiple sheets for more than one area)



On the lines below make a mark indicating how severe your discomfort is or has been

Worst pain Imaginable Feeling absolutely great

Level of discomfort right now

Best it has felt in the past week (or since the last form)

Worst it has felt in the past week (or since the last form)