PERSONAL INJURY QUESTIONAIRE

Patient Name:______________________________ Date:______________

Date of accident:________________ Time of accident:____________ am / pm

Make of your vehicle:________________ Year:______ Model:________________

Other vehicle make:________________ Year:______ Model:________________

At the time of impact was your vehicle: Moving/Stopped

Were you aware of the approaching collision prior to impact? YES/NO

Where were you seated in the vehicle? Driver /Passenger: Front/Rear (Rt / Middle / Lt)

Number of people in your vehicle:____________

What Street Were you on?________________

Were the police notified? YES/NO Did they come to the scene? YES/NO

Is there a report? YES/NO

Since this injury occurred, are your symptoms: Improving/Getting Worse/Same

Were you knocked unconscious? YES /NO If yes, how long?____________

Did you go to a hospital? YES/NO IF yes, name of hospital?________________

How did you get to the hospital? Ambulance/Private Vehicle

Were X-rays taken at the hospital? YES/NO

Have you been treated by another doctor since the accident? YES/NO

If yes, please indicate doctor's name, address, and phone number:________________

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____

Were you holding the steering wheel? YES (Right/Left/Both), NO

Was the trunk of your body pointed straight forward at the time of the collision? YES/NO

If no, how was it turned?____

Was your head pointed straight forward? YES/NO

If no, how was it turned?____

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Were you wearing a seat belt? **YES/NO** **If yes, lap seat belt _______ shoulder-lap seat belt _____**

Did the Air Bag Deploy? **YES/NO**

Did your seat have a headrest? **YES/NO** **How High:** **Top/Middle/Bottom of Head**

Did any of your body parts hit the automobile? **YES/NO**

If yes, describe: ____

Are you currently being treated for any other injury or illness? **YES/NO**

If yes, please describe in detail: ______________________________________

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Have you ever been involved in an accident before? **YES/NO**

If yes, please describe, including date(s), type of accident(s), and any injuries sustained:

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Please list any other pertinent information: ______________________________________

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Patient's Signature: ______________________________________ **Date:** ______________

Print Name ____

Guardian's Signature Authorizing Care: ________________________ **Date:** __________

Print Name ____

Doctor's Initials: ____________