Personal Injury Questionnaire

Patient Information

Patient:

First Name_____ MI_____ Last Name_____ ID#_____

Sex_____ Date of Birth_____ SSN#_____

Address_____

City_____ State_____ Zip_____

Phone (H)_____ (C)_____ (W)_____

Insured:

First Name_____ MI_____ Last Name_____

Sex_____ Date of Birth_____ SSN#_____

Address_____

City_____ State_____ Zip_____ Phone_____

Insurance:

Insurance Carrier_____

Address_____

City_____ State_____ Zip_____

Policy #_____ Claim#_____ Phone_____

Date of Injury_____ **Time of Injury**_____ **Date of First Treatment**_____

Nature of Accident

1. What was your position in the vehicle?_____
2. What type of vehicle were you driving?_____
3. What speed were you traveling at the time of the accident?_____
4. Who hit who?_____
5. What was your vehicle's part of impact? _____
6. What speed was the other vehicle traveling?_____
7. What was the other vehicle's point of impact? _____
8. Were you wearing your seat restraints? _____
9. What position were your vehicle's head rests in?_____
10. Did your vehicle's air bags deploy? _____
11. Were you prepared for the impact? _____
12. What position was your body in just prior to impact?_____
13. What happened to your body at the moment of impact? _____
14. What was your mental/emotional state immediately following the accident?_____
15. Did you receive medical attention at the scene of the accident? _____

(CONTINUE ON BACK)