PERSONAL INJURY QUESTIONNAIRE FORM

Name_____ Today's Date_____
Your Vehicle Ins. Co._____ Policy # _____
Agent's Name_____ Phone #_____
Name on Policy (if other than self) _____ Claim # _____

Responsible Party's Name_____ Phone _____
Address _____ City _____ State _____ Zip _____
Responsible Party's Ins. Co. _____ Policy # _____
Contact Person_____ Phone # _____
Ins. Co. Address _____ Claim # _____

ATTORNEY (if Applicable)
Name _____ Phone _____
Address _____ City _____ State _____ Zip _____

NATURE OF ACCIDENT:
1. Date of Accident _____ Time of Day _____ am/pm
2. City of Accident

_____
3. Were you: ( ) Driver ( ) Front Seat Passenger ( ) Back Seat Passenger (driver or passenger)( ) Other _____
4. Number of people in your vehicle? _____
5. What direction were you headed? ( ) North ( ) South ( ) East ( ) West
on (name of street) _____
6. What direction was the other vehicle heading? ( ) North ( ) South ( ) East ( ) West
on (name of street) _____
7. Were you struck from: ( ) Behind ( ) Front ( ) Left Side ( ) Right Side
8. Were you knocked unconscious? ( ) Yes ( ) No If yes, for how long? _____
9. Did the police come to the scene? ( ) Yes ( ) No Was a police report taken? ( ) Yes ( ) No
10. Did you go to the hospital? ( ) Yes ( ) No
    If yes, what is the name and city of the hospital? _____
    How did you get to the hospital? _____
    What parts of the body were x-rayed at the hospital? _____
    What did the hospital do for your injuries? _____
    How long did you stay at the hospital? _____
11. Road conditions at the time of the accident: ( ) Wet ( ) Dry ( ) Icy ( ) Other _____
12. Were you aware of the approaching collision or did the impact catch you by surprise? ( ) Aware ( ) Surprise
13. Did you experience a flash of light or explosion in your head? ( ) Yes ( ) No
14. Did you become or get ( ) confused ( ) disorientated ( ) light headed ( ) dizzy ( ) nauseated
    ( ) blurred vision ( ) ringing/buzzing in ears from the accident?
15. If you still have any of those symptoms, which ones? _____
16. Are you currently suffering from any of the following?
    ( ) Difficult Concentration
    ( ) Restlessness
    ( ) Sleeplessness
    ( ) Reduced Tolerance to heat
    ( ) Irritable
    ( ) Difficulty with memory
    ( ) Forgetfulness
    ( ) Reduced tolerance to alcohol

17. Were you wearing a seatbelt? ( ) Yes ( ) No If yes, lap belt / shoulder and lap belt (circle one)

18. List the year, make and model of the vehicle you were in:

Year _____ Make _____ Model _____

19. Was your vehicle stopped at the time of impact? ( ) Yes ( ) No

If yes, was the driver's foot also on the brake? ( ) Yes ( ) No

If no, then estimate the speed of the vehicle you were in: _____ mph

20. If your vehicle was moving at the time of impact, was it ( ) slowing down ( ) gaining speed ( ) steady speed

21. On what part of the vehicle did the following body parts hit?

Chest hit _____ Head hit _____

R/L Shoulder hit _____ R/L Arm hit _____

R/L Leg hit _____ R/L Hip hit _____

Other _____ R/L Knee hit _____

22. Did you receive any injury or bruise from the seatbelt? ( ) No ( ) Yes (describe) _____

23. What is the estimated cost of damage to the vehicle you were in? _____

24. Which of the following car parts broke in the vehicle you were in? ( ) windshield ( ) front seat back ( ) right/left side window ( ) steering wheel ( ) other

_____

25. Was the trunk of your body pointed straight forward at the time of the collision?

( ) Yes ( ) No (if no, how was it turned? _____)

26. Was your head pointed straight forward?

( ) Yes ( ) No (if no, how was it turned? _____)

27. What is the year, make and model of the other vehicle?

Year _____ Make _____ Model_____

28. What was the approximate speed of the other vehicle? _____mph

Was the other vehicle ( ) slowing down ( ) gaining speed ( ) steady speed

29. **IMPORTANT** Please describe, in your own words, what happened during this accident:

_____

_____

_____

30. Please describe how you felt:

A. DURING the accident: _____

B. IMMEDIATELY AFTER: _____

C. LATER THAT DAY: _____

D. THE NEXT DAY: _____

31. Have you lost time from work as a result of this accident? ( ) Yes ( ) No

If yes, please complete this section:

A. Last day worked: _____

B. Type of Employment: _____

C. Day returned to work: _____

D. Are you being compensated for time lost from work? ( ) Yes ( ) No

If yes, please state type of compensation: _____

E. Did you lose your job because of your injuries? ( ) Yes ( ) No

F. Have you changed employment or has your work been modified due to your injuries?

Explain: _____

32. Has your insurance company been notified of the accident? ( ) Yes ( ) No

33. Have you been involved in a car accident within the last 5 years? ( ) Yes ( ) No