



PERSONAL INJURY QUESTIONNAIRE

Name: _____ Date of Accident _____

Where did accident happen? Describe the accident in your own words: _____

What was your position in the car?

Driver: if Driver were your hands on the steering wheel? Left Right Both

Passenger: If Passenger, were you sitting in Front Right Rear Left Rear

Did your vehicle strike another vehicle? Yes No

Was your vehicle struck by another vehicle? Yes No

Angles of impact...First Collision: Front Back Left Right

If Second Collision: Front Back Left Right

Were you wearing a seat belt? Yes No

Did your brace for impact? Yes No...I braced with my hands I braced with my feet

Which way were you facing at the time of impact... straight ahead Left Right

Approximate speed of your car: _____ mph Other car _____ mph

Did you strike anything in vehicle at time of impact? Yes No

If yes, specify what part of your body struck what ie.... head chest chin shoulder Right/Left knee

Steering Wheel _____ Dashboard _____

Windshield _____ Roof _____

Left Side Door _____ Right Side Door _____

Left Side Window _____ Right Side Window _____

Other _____

Did back seat bend/break? Yes No

Immediately following the accident, how did you feel? dizzy/dazed disoriented unconscious

nervous nauseous upset weak other _____

Did you go to the hospital? Yes No Were you admitted to the hospital? Yes No if yes how long? _____

If you went to hospital, when? At time of accident Next day

How did you get to hospital? Ambulance Police Car Private Transportation

Name of Hospital: _____

Attended by Dr. _____

What treatment was given?

None Placed in a cervical collar X-rayed Given stitches Bandaged

Given pain med Given instructions regarding concussions

Given instructions regarding sprains and strains Physical Therapy

Instructed to call a Orthopedic Surgeon Instructed to call a private physician

Referred to this office for treatment Other _____

Have you seen any other doctor as a result of this accident? Yes No

Doctor's name
