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ISELIN, NEW JERSEY 08830

PERSONAL INJURY QUESTIONNAIRE

Name _____ Date of Birth _____ Phone_____

Address _____ City_____ State_____ Zip_____

Employer's Name _____ Employer's Address _____

Your Ins. Co. _____ Policy #_____ Agent's Name_____

Driver/Other Vehicle _____ Ins. Co._____ Policy #_____

Have you retained an attorney? ( ) Yes ( ) No Name _____

Were there any witnessess? ( ) Yes ( ) No Name(s)_____

NATURE OF ACCIDENT:

1. Date of Accident_____ Time of Day_____
2. Were you: ( ) Driver ( ) Passenger ( ) Front Seat ( ) Back Seat
3. Number of people in your vehicle?_____ Other vehicle?_____
4. What direction were you headed? ( ) North ( ) East ( ) South ( ) West

   on (name of street)_____
5. What direction was other vehicle headed? ( ) North ( ) East ( ) South ( ) West

   on (name of street)_____
6. Were you struck from: ( ) Behind ( ) Front ( ) Left side ( ) Right side
7. Were you knocked unconscious? ( ) Yes ( ) No. If yes, for how long? _____
8. Were police notified? ( ) Yes ( ) No
9. In your own words, please describe accident: _____

   _____

   _____

   _____
10. Did you have any physical complaints BEFORE THE ACCIDENT? ( ) Yes ( ) No. If yes, please describe in detail:

    _____

    _____

    _____
11. Please describe how you felt:

    a. DURING the accident: _____

    b. IMMEDIATELY AFTER the accident: _____

    c. LATER THAT DAY: _____

    d. THE NEXT DAY:_____
12. What are your PRESENT complaints and symptoms?_____

    _____

    _____

13. Do you have any congenital (from birth) factors which relate to this problem? ( )Yes ( )No. If yes, please describe: _____

14. Do you have any previous illnesses which relate to this case? ( ) Yes ( ) No. If yes, please describe: _____

_____

15. 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 as injury(ies) received. _____

_____

_____

16. Where were you taken after the accident? _____

17. Have you been treated by another doctor since the accident? ( ) Yes ( ) No. If yes, please list doctor's name and address: _____

What type of treatment did you receive? _____

_____

18. Since this injury occurred, are your symptoms: ( ) Improving ( ) Getting Worse ( ) Same

19. CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT:

☐ Headache	☐ Irritability	☐ Numbness in Toes	☐ Face Flushed	☐ Feet Cold
☐ Neck Pain	☐ Chest Pain	☐ Shortness of Breath	☐ Buzzing in Ears	☐ Hands Cold
☐ Neck Stiff	☐ Dizziness	☐ Fatigue	☐ Loss of Balance	☐ Stomach Upset
☐ Sleeping Problems	☐ Head Seems Too Heavy	☐ Depression	☐ Fainting	☐ Constipation
☐ Back Pain	☐ Pins & Needles in Arms	☐ Lights Bother Eyes	☐ Loss of Smell	☐ Cold Sweats
☐ Nervousness	☐ Pins & Needles in Legs	☐ Loss of Memory	☐ Loss of Taste	☐ Fever
☐ Tension	☐ Numbness in Fingers	☐ Ears Ring	☐ Diarrhea	☐ _____

Symptoms Other Than Above _____

20. Have you lost time from work as a result of this accident? ( ) Yes ( ) No. If yes, please complete this question.

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, please state type of compensation you are receiving: _____

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

_____

_____

_____

22. Other pertinent information: _____

_____

_____

_____

_____

_____ _____

DATE PATIENT'S SIGNATURE