PERSONAL INJURY QUESTIONNAIRE

Home Phone ( ) _____

Name _____ Work Phone ( ) _____

Address _____ City _____ State _____ Zip _____

Age _____ Birthdate _____ Marital Status _____ Sex _____ S/S # _____

Employer's Name _____ Employer's Address _____

Your Ins. Co. _____ Policy # _____ Adjuster's Name _____

Name on Policy (if other than self) _____ Claim # _____

Ins. Co. Address _____ City _____ State _____ Zip _____

Ins. Co. Phone # _____ Ext. _____

ATTORNEY

Name _____ Phone ( ) _____

Address _____ City _____ State _____ Zip _____

Were there any witnesses? ☐ 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? _____ Were you wearing seat belts? _____
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. Approximate speed of your car _____ mph Other car _____ mph
8. Were you knocked unconscious? ☐ Yes ☐ No If yes, for how long? _____
9. What position was your head at time of impact? Looking straight ahead_____ Turned Left_____ Turned Right_____
10. Were police notified? ☐ Yes ☐ No
11. In your own words, please describe accident: _____
12. Did you have any physical complaints BEFORE THE ACCIDENT? ☐ Yes ☐ No If yes, please describe in detail:
13. Please describe how you felt:
    a. DURING the accident: _____
    b. IMMEDIATELY AFTER the accident: _____
    c. LATER THAT DAY: _____
    d. THE NEXT DAY: _____