

# 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: \_\_\_\_\_

