Personal Injury Questionnaire

Client Information

- Name:_____
- Address: _____
- Date of Birth: _____
- Social Security No:_____
- Email address: _____
- Phone Number(s): _____

Accident Information

- Date of accident:_____
- Location of Accident:_____
- Police Agency investigating Accident:_____
- Driver Exchange Information:_____
- Have you spoke to an insurance adjuster:_____
    - Identify company of adjuster:_____
    - Did you give a recorded statement:_____
        - Date of statement:_____

Vehicle Information (Plaintiff-You)

- Insurance Carrier:_____
- Insurance Adjuster:_____
- Claim Number:_____
- Type of Vehicle:_____
- Description of Damage (location of impact):_____
- Dollar Value of Damage:_____
- Location of Vehicle:_____
- Do you have photographs of vehicle:_____
- Did airbags deploy:_____

Vehicle Information (Defendant - car that hit you)

- Insurance Carrier:_____
- Insurance Adjuster:_____
- Claim Number:_____
- Type of Vehicle:_____
- Description of Damage (location of impact):_____
- Dollar Value of Damage:_____

- Location of Vehicle:_____
- Do you have photographs of vehicle:_____
- Did airbags deploy:_____

Employment in formation (Type of Work, i.e. sitting, walking etc):

- Describe work (i.e. tasks required for job):_____
- Have you lost time from work:_____
    - Hours lost:_____
    - Pay rate:_____
      Lost time form Work (this accident)

Injury

- When did you first notice you were injured:_____
- Did any part of your body impact with the vehicle:_____
    - Describe:_____
- Did you receive lacerations:_____
    - Describe:_____
    - scar/location: _____
- Describe your pain and injuries (start at the top of your head - down to toes)

  _____
  _____
  _____
  _____

Treatment Providers (list in chronological order - first one see to last)

1:

- Name of Provider :_____
- Type of Provider (medical discipline):_____
- Type of Treatment Received:_____
- Address:_____
- Phone Number:_____
- Date first seen:_____

2:

- Name of Provider :_____
- Type of Provider (medical discipline):_____
- Type of Treatment Received:_____
- Address:_____
- Phone Number:_____
- Date first seen:_____

3:

- Name of Provider :_____
- Type of Provider (medical discipline):_____
- Type of Treatment Received:_____

- Address:_____
- Phone Number:_____
- Date first seen:_____

4:

- Name of Provider :_____
- Type of Provider (medical discipline):_____
- Type of Treatment Received:_____
- Address:_____
- Phone Number:_____
- Date first seen:_____

5:

- Name of Provider :_____
- Type of Provider (medical discipline):_____
- Type of Treatment Received:_____
- Address:_____
- Phone Number:_____
- Date first seen:_____

6:

- Name of Provider :_____
- Type of Provider (medical discipline):_____
- Type of Treatment Received:_____
- Address:_____
- Phone Number:_____
- Date first seen:_____

7:

- Name of Provider :_____
- Type of Provider (medical discipline):_____
- Type of Treatment Received:_____
- Address:_____
- Phone Number:_____
- Date first seen:_____

8:

- Name of Provider :_____
- Type of Provider (medical discipline):_____
- Type of Treatment Received:_____
- Address:_____
- Phone Number:_____
- Date first seen:_____

Facts of Accident

- Time of accident:_____
- Where were you coming from or going to:_____
- Passengers
    - Name:_____
    - Address:_____
- Speed (if you know it)_____
- Distractions: (i.e. using phone, eating):_____
- Weather conditions:_____

Prior Medical History (last ten years)

- **List all injuries**
    - **Body Part**
      _____
      _____
      _____
      _____
- Health issues:
  _____
  _____
  _____
- Treatment_____
  _____
  _____

Prior Accidents/Injuries

- **Prior injuries (sports etc):**_____
    - Date:_____
    - Type of injury:_____
    - Treatment received:_____

- **Prior auto accidents:**
    - Date:_____
    - Were you injured:_____
        - Result of Injury:_____
        - Treatment received:_____
        - Lawsuit/claim:_____

List of all Medical Providers (five (5) years back in time from the date of the accident)

1.

- **Name of Provider :**_____

- **Type of Provider (medical discipline):**_____
- **Type of Treatment Received:**_____
- **Address:**_____
- **Phone Number:**_____
- **Approximate dates of treatment:**_____

2.

- **Name of Provider :**_____
- **Type of Provider (medical discipline):**_____
- **Type of Treatment Received:**_____
- **Address:**_____
- **Phone Number:**_____
- **Approximate dates of treatment:**_____

3.

- **Name of Provider :**_____
- **Type of Provider (medical discipline):**_____
- **Type of Treatment Received:**_____
- **Address:**_____
- **Phone Number:**_____
- **Approximate dates of treatment:**_____

4.

- **Name of Provider :**_____
- **Type of Provider (medical discipline):**_____
- **Type of Treatment Received:**_____
- **Address:**_____
- **Phone Number:**_____
- **Approximate dates of treatment:**_____

5.

- **Name of Provider :**_____
- **Type of Provider (medical discipline):**_____
- **Type of Treatment Received:**_____
- **Address:**_____
- **Phone Number:**_____
- **Approximate dates of treatment:**_____

6.

- **Name of Provider :**_____
- **Type of Provider (medical discipline):**_____
- **Type of Treatment Received:**_____
- **Address:**_____

- **Phone Number:_____**
- **Approximate dates of treatment:_____**