PERSONAL INJURY QUESTIONNAIRE

Name:____ Today's Date: _________________

Date of Accident: ________________________________ Time of Day: __________________

Were you the: Driver Front Seat Passenger Back Seat Passenger
Number of people in your vehicle: __________
Your vehicle was: Stopped Moving Starting Slowing Down

Name of street that you were on: ____
Make, Model and Year of your vehicle: ____
Make, Model and Year of the other vehicle: _______________________________________
The force of impact was: Mild Moderate Severe
Were you struck from: Behind Front Left Right
Approximate speed of your car: _______ mph

Was your car drivable after the accident? Yes No
Were you wearing both a lap and shoulder belt? Yes No
Did your seat have a headrest or high-backed seat? Yes No
Did you strike any part of your body against the car? Yes No
If yes, please describe: ____
____

Did you lose consciousness? Yes No If so, for how long? __________________________
Were the police notified? Yes No If yes, did you get a copy of the police report? ________

In your own words, describe the accident: ____
____
____

Did you have any physical complaints BEFORE THE ACCIDENT? Yes No
If yes, please describe in detail: ____
____
____
____

Immediately after the accident, did you experience any of the following:

Dazed	Shocked	Vomiting	Dizziness	Lightheadedness
Nausea	Headache	Numbness	Pain	Blurred Vision

If you had pain immediately, please describe where: _________________________________
____
____

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Did you experience pain: Hours Later The Next Day Days Later

If so, where? ____

____

____

After the accident, did you experience any of the following:

Bleeding: __________ If so, where: ______________________________

Bruising: __________ If so, where: ______________________________

Swelling: __________ If so, where: ______________________________

Is your pain worse with coughing, sneezing, or straining? Yes No

If yes, please describe where it hurts: ______________________________

____

____

Where were you taken after the accident? ______________________________

Has another doctor treated or examined you since the accident? Yes No

If yes, please list doctor's name, address and phone number: ____________________

____

____

Have you had x-rays for your injuries? Yes No

Was an MRI performed? Yes No If so, of what area? ____________________

Did you receive physiotherapy? Yes No If so, did it help? Yes No

Did you receive medication? Yes No If so, what kind? ____________________

Did it help? Yes No Some

Have you had any new injuries or accidents since the above injury? Yes No

Are you presently doing the same work as before the injury? Yes No

Do you have any disabilities due to the injury? Yes No

Have you lost any time from work as a result of the accident? Yes No

If yes, please state the last date worked: ______________________________

Type of employment: ______________________________

Are you being compensated for time lost from work? Yes No

If yes, please state the type of compensation you are receiving: ____________________

Circle the symptoms you have noticed since the accident:

Neck Pain   Neck Stiffness   Upper Back Pain   Lower Back Pain

Pain Across the Shoulders   Pain Between the Shoulders   Mid Back Pain

Shortness of Breath   Head Feels Heavy   Headache   Ringing in the Ears

Blurred Vision   Difficulty Swallowing   Light Bothering Eyes   Lightheadedness

Dizziness   Depression   Fatigue   Insomnia   Irritability   Nervousness

Cold Sweats   Poor Concentration   Loss of Memory   Loss of Smell

Loss of Taste   Cold Hands   Pins & Needles in Hands/Arms   Pain Down Arm

Numb Fingers   Numbness in Hands/Arms   Weakness in Grip/Hands/Arms

Pain in Hands   Pain Down Legs   Cold Feet   Leg Cramps

Numbness in Legs/Feet   Diarrhea   Constipation   Jaw Pain

Have your symptoms caused any difficulty with:

Work	Yes	No
Sleep	Yes	No
Exercise	Yes	No
Home Life	Yes	No
Driving	Yes	No

I have pain in my: ____

It began: Immediately   Hours Later   Days Later

The pain is: Getting Better   Staying the Same   Getting Worse

I would rate this condition: (No Pain) 0…..1.....2…..3…..4…..5…..6…..7…..8…..9…..10 (Severe Pain)

I feel the pain: 75-100%   50-75%   25-50%   less than 25% of the day

The pain feels: Dull   Sharp   Aching   Burning   Stabbing

The pain gets better with: ____

The pain gets worse with: ____

EXECUTIVE ER

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