PERSONAL INJURY QUESTIONNAIRE

Name _____ Date of Birth _____ Phone _____

Address: _____ City: _____ State: _____ ZIP: _____

Employer's Name: _____ Employer's Address: _____

Your Ins. Co.: _____ Policy #: _____ Claim #: _____

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

Have you retained an attorney?: _____ Attorney's Name: _____

Were there any witnesses?: _____ 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 the 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 the 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: _____
_____
_____

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