

**PERSONAL INJURY QUESTIONNAIRE**

The information you provide in this questionnaire is confidential. Please answer every question fully – one incorrect or incomplete answer could prevent us from properly advising you and might seriously harm your case.

(Please print)

TODAY'S DATE: \_\_\_\_\_

**I. PERSONAL INFORMATION**

NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
(Street) (Apt.)

\_\_\_\_\_  
(City) (State) (Zip code) (County)

Emergency Phone Number (Friend or Relative) \_\_\_\_\_

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

How did you learn of this office (Check One): Friend \_\_\_\_\_

Newspaper \_\_\_\_\_ Yellow Pages \_\_\_\_\_ Other \_\_\_\_\_

EMPLOYER: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_

Phone: \_\_\_\_\_ Date Started with this Employer: \_\_\_\_\_

No. of days out due to injuries: \_\_\_\_\_

Are you currently out of work due to your injuries: \_\_\_\_\_

MARITAL STATUS: Single \_\_\_\_\_ Married \_\_\_\_\_ Separated \_\_\_\_\_ Divorced \_\_\_\_\_

If married, name of spouse: \_\_\_\_\_

**II. INSURANCE INFORMATION**

AUTO INSURANCE COMPANY: \_\_\_\_\_

Have you reported accident? \_\_\_\_\_ Agent's Name: \_\_\_\_\_

HEALTH INSURANCE COMPANY: \_\_\_\_\_

OTHER INSURANCE (ex. Disability): \_\_\_\_\_

OTHER PARTY'S INSURANCE COMPANY: \_\_\_\_\_

III. **COLLISION INFORMATION**

DATE OF ACCIDENT: \_\_\_\_\_ Time: \_\_\_\_\_

WEATHER AND ROAD CONDITIONS: \_\_\_\_\_

WAS THERE A POLICE REPORT MADE: \_\_\_\_\_ COPY AVAILABLE?

Did anyone receive a ticket? \_\_\_\_\_ If yes, list the following

Person(s) charged: \_\_\_\_\_

Violation(s): \_\_\_\_\_

TRAFFIC COURT DATE: \_\_\_\_\_ TIME \_\_\_\_\_ PLACE \_\_\_\_\_

LOCATION OF ACCIDENT

Road you were on at time of collision: \_\_\_\_\_

Nearest major crossroads: \_\_\_\_\_

Familiar nearby landmarks: \_\_\_\_\_

YOUR AUTOMOBILE (Year and Make): \_\_\_\_\_

Location of your care: \_\_\_\_\_

Is it derivable? \_\_\_\_\_

Where on your car is the damage? \_\_\_\_\_

Do you have collision insurance? \_\_\_\_\_ If yes, how much deductible? \_\_\_\_\_

PASSENGERS IN YOUR VEHICLE: \_\_\_\_\_

WITNESSES: \_\_\_\_\_

FACTS (Please give a description of what happened just before, during and after the accident):

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IV. **INJURIES**

Please describe your injuries and physical problems as completely as possible including such things as broken bones, scars, headaches, back and neck pains, swelling, cuts and bruises, vomiting, dizziness, blurred vision, change in appetite, difficulty sleeping, etc.

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Please describe what happened during the accident that may have caused these injuries, example: headaches due to hitting windshield:

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If you have been treated for your injuries either at a hospital or by a private doctor, please fill in the following information:

HOSPITAL:

Name: \_\_\_\_\_ Date Admitted: \_\_\_\_\_

DOCTOR:

Name: \_\_\_\_\_ Date started treatment: \_\_\_\_\_

\_\_\_\_\_

V. **HISTORY**

MEDICAL: Please state whether you have suffered any of the following:

Auto Accident Injuries: Yes \_\_\_\_\_ No \_\_\_\_\_

Work-related Injuries: Yes \_\_\_\_\_ No \_\_\_\_\_

Serious Injuries: Yes \_\_\_\_\_ No \_\_\_\_\_

Serious Illnesses: Yes \_\_\_\_\_ No \_\_\_\_\_

CLAIMS: Please state whether you have ever been involved in the following:

Prior Automobile Accident: Yes \_\_\_\_\_ No \_\_\_\_\_

Workers' Compensation Claim: Yes \_\_\_\_\_ No \_\_\_\_\_

A Prior Injury Claim: Yes \_\_\_\_\_ No \_\_\_\_\_

Prior Lawsuits: Yes \_\_\_\_\_ No \_\_\_\_\_

Please check any of the following items that you have with you and please have them ready for the consultation:

Copies of medical bill(s) \_\_\_\_\_

Police Report \_\_\_\_\_

Automobile Insurance Policies \_\_\_\_\_

Traffic ticket(s) \_\_\_\_\_

Traffic Court Summons \_\_\_\_\_