

# PERSONAL INJURY QUESTIONNAIRE

Name \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Age \_\_\_\_\_ Birthdate \_\_\_\_\_ Sex \_\_\_\_\_ S/S # \_\_\_\_\_

Employer's Name \_\_\_\_\_ Employer's Address \_\_\_\_\_

Your Ins. Co. \_\_\_\_\_ Policy # \_\_\_\_\_ Agent's Name \_\_\_\_\_

Name on Policy (If other than self) \_\_\_\_\_ Policy # \_\_\_\_\_

Responsible Party's Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Policy Holder's Name \_\_\_\_\_ Policy # \_\_\_\_\_

## 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. Were police notified? ( ) Yes ( ) No
10. In your own words, please describe accident: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
11. Did you have any physical complaints BEFORE THE ACCIDENT? ( ) Yes ( ) No If yes, please describe in detail: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
12. Please describe how you felt:
  - a. DURING the accident: \_\_\_\_\_
  - b. IMMEDIATELY AFTER the accident: \_\_\_\_\_
  - c. LATER THAT DAY: \_\_\_\_\_
  - d. THE NEXT DAY: \_\_\_\_\_