

PERSONAL INJURY QUESTIONNAIRE

Today's Date: _____

Patient's Name: _____
(Last name) (First name) (M.I.)

Date of Injury: _____

Where did Injury Occur? _____

Please describe in your own words what happened in during the injury.

Where did this injury occur?

- Indoors
 Outdoors
 Other _____

What were the conditions at the time of the injury?

Time of day:

- Full daylight
 Dusk
 Night

Conditions:

- Dry
 Damp
 Wet
 Snow-covered
 Ice-covered
 Patchy Ice/Snow

Visibility:

- Excellent
 Good
 Fair
 Poor

Visibility compromised by:

- Brightness
 Darkness
 Rain
 Snow
 Fog
 Traffic

Please describe the moment of impact during the injury

Were you:

- Totally unaware that the injury was impending
 Aware that the injury was impending
 Aware that the injury was impending and braced for it

Did you lose consciousness?

- Yes
- No

Immediately following the injury, did you feel?

- Dizzy
- Dazed
- Disoriented
- Weak
- Nervous
- Nauseated

Were you able to walk unaided?

- Yes
- No

Where did you go...?

- Drove home
- Was driven home
- Drove to hospital
- Was driven to hospital
- Taken to hospital via ambulance
- Drove to work
- Was driven to work
- Drove to school
- Was driven to school

Hospital Name: _____

Date of hospital visit: ____ / ____ / ____

Were you admitted to the Hospital?: Yes/ No

Next day discomfort?

- increased
- decreased
- remained the same

Did your major complaints exist before the injury?

- Yes
- No

In what areas did you IMMEDIATELY feel pain?

- | | | | | | | |
|-------------------------------------|---------------------------------|-------------------------------|--------------------------------|-------|-------------------------------|--------------------------------|
| <input type="checkbox"/> Head | Shoulder | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Hip | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Neck | Arm | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Thigh | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Upper back | Elbow | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Knee | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Mid back | Wrist | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Calf | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Ribs | Hand | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Ankle | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Chest | Fingers | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Foot | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Abdomen | Buttock | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Toes | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Low Back | <input type="checkbox"/> Pelvis | | | | | |

Did you feel any numbness or tingling?

- Yes If so, describe where: _____
- No

In what areas (if any) did you experience lacerations (cuts)?

- | | | | | | | |
|-------------------------------------|---------------------------------|-------------------------------|--------------------------------|-------|-------------------------------|--------------------------------|
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| <input type="checkbox"/> Low Back | <input type="checkbox"/> Pelvis | | | | | |

If you went to the hospital, what areas were x-rayed?

- | | | | | | | |
|-------------------------------------|---------------------------------|-------------------------------|--------------------------------|-------|-------------------------------|--------------------------------|
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| <input type="checkbox"/> Low Back | <input type="checkbox"/> Pelvis | | | | | |

Where did you experience pain on the day FOLLOWING the injury?

- | | | | | | | |
|-------------------------------------|---------------------------------|-------------------------------|--------------------------------|-------|-------------------------------|--------------------------------|
| <input type="checkbox"/> Head | Shoulder | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Hip | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
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As result of the injury, did you have to take time off from work or school?

- Yes If so, give dates missed: _____
 No

Do you have an attorney: Yes/ No

Attorney's information: Name: _____

Address: _____

Phone #: _____

Insurance information: Name: _____

Address: _____

Phone #: _____

Claim #: _____

Contact Person: _____

Patient's Signature: _____