## PERSONAL INJURY QUESTIONNAIRE

(FORM UPDATED 05/23/2020)

You were the: Driver   Front Passenger   Rear Passenger   Pedestrian   # of people in the vehicle: # of people in the other vehicle:  Collision: Rear-End   Side: Left   Right   Head-On   Parked   Other:  Road condition: Dry   Wet   Icy   Road Surface: Asphalt   Gravel   Dirt   Your vehicle: Compact   Mid - size   Truck   SUV   Other:  Other vehicle: Compact   Mid - size   Truck   SUV   Other:  Your speed at the time of accident: Estimate mph  Body Position at time of impact: Facing straight ahead   Head Turned   Right   Left    Does your vehicle have a headrest? Yes   No   If yes, approximately how far was the top of the headrest from the top of your head? _ Above   Below    Were you wearing a seatbelt? No   Yes   Lap   Shoulder   Lap and Shoulder    Any bruising or soreness from the seat belt? No   Yes   Explain  Did your vehicle strike another car? Yes   No    Did girbags deploy? If so, which ones? Driver   Passenger   Left Side   Right Side    Were you aware of the approaching collision prior to impact? Yes   No	loday's Date:		
Adjuster's Name & #:	Name:	Date of Accident:	
Ins. Co. & Policy #:	Your Ins. Co & Policy #:	Agent's Name & #:	
NATURE OF ACCIDENT  You were the: Driver   Front Passenger   Rear Passenger   Pedestrian   # of people in the vehicle: # of people in the other vehicle:  Collision: Rear-End   Side: Left   Right   Head-On   Parked   Other:  Road condition: Dry   Wet   Icy   Road Surface: Asphalt   Gravel   Dirt   Your vehicle: Compact   Mid - size   Truck   SUV   Other:  Other vehicle: Compact   Mid - size   Truck   SUV   Other:  Your speed at the time of accident: Estimate mph  Body Position at time of impact: Facing straight ahead   Head Turned   Right   Left    Does your vehicle have a headrest? Yes   No   If yes, approximately how far was the top of the headrest from the top of your head? Above   Below    Were you wearing a seatbelt? No   Yes   Lap   Shoulder   Lap and Shoulder    Any bruising or soreness from the seat belt? No   Yes   Explain  Did your vehicle strike another car? Yes   No    Did dirbags deploy? If so, which ones? Driver   Passenger   Left Side   Right Side    Were you aware of the approaching collision prior to impact? Yes   No    Condition of your vehicle after impact: Drivable   Totaled    Police report issued? Yes   No   Traffic violation issued? Yes   No    Brief explanation of accident:	Your Ins. PIP Claim#:	Adjuster's Name & #:	
You were the: Driver   Front Passenger   Rear Passenger   Pedestrian   # of people in the vehicle: # of people in the other vehicle:  Collision: Rear-End   Side: Left   Right   Head-On   Parked   Other:  Road condition: Dry   Wet   Icy   Road Surface: Asphalt   Gravel   Dirt   Your vehicle: Compact   Mid - size   Truck   SUV   Other:  Other vehicle: Compact   Mid - size   Truck   SUV   Other:  Your speed at the time of accident: Estimate mph  Body Position at time of impact: Facing straight ahead   Head Turned   Right   Left    Does your vehicle have a headrest? Yes   No   If yes, approximately how far was the top of the headrest from the top of your head? Above   Below    Were you wearing a seatbelt? No   Yes   Lap   Shoulder   Lap and Shoulder    Any bruising or soreness from the seat belt? No   Yes   Explain  Did your vehicle strike another car? Yes   No    Did gour vehicle strike another object? Yes   No    Did airbags deploy? If so, which ones? Driver   Passenger   Left Side   Right Side    Were you aware of the approaching collision prior to impact? Yes   No    Condition of your vehicle after impact: Drivable   Totaled    Police report issued? Yes   No   Traffic violation issued? Yes   No    Brief explanation of accident:	Driver / Other Vehicle: Ir	ns. Co. & Policy #:	
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Road condition: Dry   Wet   Icy   Road Surface: Asphalt   Gravel   Dirt   Your vehicle: Compact   Mid - size   Truck   SUV   Other:   Other vehicle: Compact   Mid - size   Truck   SUV   Other:   Mid - size   Mid - siz	# of people in the vehicle: # of people	e in the other vehicle:	
Your vehicle: Compact   Mid - size   Truck   SUV   Other:   Other vehicle: Compact   Mid - size   Truck   SUV   Other:   Other vehicle: Compact   Mid - size   Truck   SUV   Other:   Other vehicle: Compact   Mid - size   Truck   SUV   Other:   Oth	<b>Collision:</b> Rear-End ☐ Side: Left ☐ Right ☐	Head-On Parked Other:	
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Neadrest from the top of your head? Above Below	Body Position at time of impact: Facing straigh	nt ahead $\square$ Head Turned $\square$ Right $\square$ Left $\square$	
Any bruising or soreness from the seat belt? No Yes Explain  Did your vehicle strike another car? Yes No Did your vehicle strike another object? Yes No Did airbags deploy? If so, which ones? Driver Passenger Left Side Right Side Were you aware of the approaching collision prior to impact? Yes No Condition of your vehicle after impact: Drivable Totaled Police report issued? Yes No Traffic violation issued? Yes No Brief explanation of accident:			
Did your vehicle strike another car? Yes  No  Did your vehicle strike another object? Yes  No  Did airbags deploy? If so, which ones? Driver  Passenger  Left Side  Right Side  Were you aware of the approaching collision prior to impact? Yes  No  Condition of your vehicle after impact: Drivable  Totaled  Police report issued? Yes  No  Traffic violation issued? Yes  No  No  No  No  No  No  No  No  No  N	Were you wearing a seatbelt? No $\square$ Yes $\square$	Lap  Shoulder  Lap and Shoulder	
Did your vehicle strike another object? Yes No Passenger Left Side Right Side  Did airbags deploy? If so, which ones? Driver Passenger Left Side Right Side  Were you aware of the approaching collision prior to impact? Yes No  Condition of your vehicle after impact: Drivable Totaled  Police report issued? Yes No Traffic violation issued? Yes No  Brief explanation of accident:	Any bruising or soreness from the seat belt? No Tyes Explain		
Did airbags deploy? If so, which ones? Driver  Passenger Left Side Right Side   Were you aware of the approaching collision prior to impact? Yes No   Condition of your vehicle after impact: Drivable Totaled   Police report issued? Yes No Traffic violation issued? Yes No   Brief explanation of accident:   NATURE OF INJURY	Did your vehicle strike another car? Yes No No		
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Condition of your vehicle after impact: Drivable  Totaled  Police report issued? Yes  No  No  No  No  No  No  No  No  No  N	<b>Did airbags deploy? If so, which ones?</b> Driver □ Passenger □ Left Side □ Right Side □		
Police report issued? Yes No Traffic violation issued? Yes No Brief explanation of accident:  NATURE OF INJURY	Were you aware of the approaching collision prior to impact? Yes $\square$ No $\square$		
Brief explanation of accident:  NATURE OF INJURY	Condition of your vehicle after impact: Drivable 🗌 Totaled 🔲		
NATURE OF INJURY	Police report issued? Yes $\square$ No $\square$ Traffic viole	ation issued? Yes $\square$ No $\square$	
NATURE OF INJURY	Brief explanation of accident:		
NATURE OF INJURY			
injuries occurrea at time ot accident:			
	injuries occurred at time of accident:		

Did you receive first aid at the scene of the accident? Yes $\square$ No $\square$ N/A $\square$		
Did you receive any medical care following the accident? Yes $\square$ No $\square$		
If yes, where were you treated, when were you treated and by whom?		
What type of treatment did you receive?		
Did you have any physical complaints BEFORE THE ACCIDENT If yes, describe in detail		
What are your PRESENT complaints and symptoms?		
Parts of the body struck:		
Since this injury occurred, are your symptoms: Improving $\Box$	☐ Getting Worse ☐ Same ☐	
CHECK SYMPTOMS THAT YOU HAVE NOTICED SINCE ACCIDE	NT:	
☐ Headache ☐ Neck Pain ☐ Neck Stiffness ☐ Upper-bac	k Pain Mid-back Pain	
☐ Low-back Pain ☐ Hip Pain ☐ Knee Pain ☐ Loss of Balar	nce 🗌 Shoulder Pain 🗌 Elbow Pain	
☐ Wrist Pain ☐ Arm Pain ☐ Leg Pain ☐ Chest Pain ☐ Dizz	iness 🗌 Fainting 🔲 Fever 🗌 Diarrhea	
☐ Constipation ☐ Fatigue ☐ Foot Pain ☐ Irritability ☐ Sleep	oing Problems□ Shortness of Breath	
☐ Pins & Needles in Arms ☐ Pins & Needles in Legs ☐ Loss	of Memory 🗌 Ears Ringing	
☐ Numbness in Fingers ☐ Numbness in Toes ☐ Face Flush	ned  Cold Sweats Depression	
☐ Nervousness☐ Cold Feet☐ Cold Hands☐ Light sensi	tivity	
Symptoms other than above:		
Other Pertinent information:		
I attest that all of the information I have given is truthful and	I accurate to the best of my ability.	
Patient's Signature:	Date:	