

MVC - PERSONAL INJURY QUESTIONNAIRE

Name _____ Date of Birth: _____

Your Vehicle Insurance Company _____ 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 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 the 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: _____

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13. What are your PRESENT complaints and symptoms: _____

14. Do you have any congenital (from birth) factors which relate to this problem? Yes No If yes, please describe: _____

15. Do you have any previous illnesses which relate to this case? Yes No If yes, please describe: _____

16. Have you been involved in an accident before? Yes No If yes, please describe; include date(s), type(s) of accident(s), as well as any injuries: _____

17. Where were you taken after the accident? _____
18. Have you been treated by another provider since the accident? Yes No If yes, please give provider's name, address, and phone number: _____
What type of treatment did you receive? _____

19. Since the injury occurred are your symptoms: improving getting worse the same
20. Check any symptoms you have noticed since the accident:
- | | | | | |
|--|---|--|--|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Irritability | <input type="checkbox"/> Numbness in toes | <input type="checkbox"/> Face flushed | <input type="checkbox"/> Feet cold |
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Buzzing in ears | <input type="checkbox"/> Hands cold |
| <input type="checkbox"/> Neck stiff | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Stomach upset |
| <input type="checkbox"/> Sleeping problems | <input type="checkbox"/> Head seems heavy | <input type="checkbox"/> Depression | <input type="checkbox"/> Fainting | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Back pain | <input type="checkbox"/> Pins & needles in arms | <input type="checkbox"/> Lights bother eyes | <input type="checkbox"/> Loss of smell | <input type="checkbox"/> Cold sweats |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Pins & needles in legs | <input type="checkbox"/> Loss of memory | <input type="checkbox"/> Loss of taste | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Tension | <input type="checkbox"/> Numbness in fingers | <input type="checkbox"/> Ears ringing | <input type="checkbox"/> Diarrhea | |

Other symptoms: _____
21. Have you lost time from work as a result of this accident? Yes No If yes, please complete this section:
a. Last day worked _____
b. Type of employment _____
c. Are you receiving disability compensation? Yes No

22. Are you restricting any activities as a result of this injury? Yes No If yes, please describe: _____

23. Other pertinent information: _____

DATE

PATIENT'S SIGNATURE