

Date _____

Personal Injury Questionnaire – Neck

Name _____ Date of Birth _____

Have you retained an Attorney? Yes No If yes, please indicate name _____

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? _____ Other vehicle? _____

4. What direction were you headed? North East South West

5. What direction was the other vehicle heading? North East South West

6. Were you struck from: Behind Front Left Side Right Side

7. Were airbags deployed? Yes No

8. Were you wearing your seatbelt? Yes No

9. Were you knocked unconscious? Yes No If yes, for how long? _____

10. Were the police notified? Yes No

11. In your own words, please describe the accident. _____

12. Where were you taken after the accident? _____

13. Please describe how you felt:

a) DURING the accident: _____

b) IMMEDIATELY AFTER the accident: _____

c) LATER THAT DAY: _____

d) THE NEXT DAY: _____

14. What are your PRESENT complaints and symptoms? _____

15. Have you been treated by another doctor/therapist since the accident? Yes No
If yes, please list the doctor/therapist's name and address: _____

16. Have you had any x-rays taken since the accident? Yes No
If yes, what areas of the body were x-rayed? _____
At which facility were these x-rays taken? _____

17. Since this injury occurred, are your symptoms: Improving Getting Worse Same

18. CHECK THE SYMPTOMS YOU HAVE NOTICED **SINCE** THE ACCIDENT?

- | | | | | |
|--|---|--|--|--|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Irritability | <input type="checkbox"/> Numbness | <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"/> Light bothers 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 ring | <input type="checkbox"/> Diarrhea | |

PREVIOUS CONDITION

19. Did you have any physical complaints BEFORE the accident? Yes No
If yes, please describe in detail. _____

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

21. Do you have any previous illnesses which relate to this case? Yes No
If yes, please describe, including date(s) and type(s) of accidents, as well as injury(ies) received.

DISABILITY

22. Have you lost time from work as a result of the accident? Yes No

If yes, please indicate:

a) Last day worked: _____

b) Type of employment: _____

c) Are you being compensated for time lost from work? Yes No

If yes, please describe the type of compensation. _____

23. Did you notice any activity restrictions as a result of this injury? Yes No

If yes, please describe in detail. _____

24. Other pertinent information. _____

Patient Signature

Date