

# **PERSONAL INJURY QUESTIONNAIRE** Non- Automobile or Workers Compensation

**Please answer all of the following questions completely.**

1. Name \_\_\_\_\_
2. Address \_\_\_\_\_  
City, State, Zip \_\_\_\_\_
3. Phone Number: Home \_\_\_\_\_ Work \_\_\_\_\_
4. Please describe the injury in your own words:  
\_\_\_\_\_  
\_\_\_\_\_
5. Was there anything in particular that you think caused the injury: example: wet floor  
Please Describe \_\_\_\_\_  
\_\_\_\_\_
6. Where did the injury occur? \_\_\_\_\_
7. City/Town: \_\_\_\_\_ State: \_\_\_\_\_ Telephone # \_\_\_\_\_
8. Date of injury: \_\_\_\_\_ Time: \_\_\_\_\_ AM PM
9. Did anyone witness your injury?  Yes  No Who? \_\_\_\_\_
10. Did you report the injury to anyone  Yes  No To Whom? \_\_\_\_\_
11. Was the report written  verbal
12. Have you retained an attorney  No
13. If Yes, please give name and address: \_\_\_\_\_  
\_\_\_\_\_
14. Immediately after the injury were you:  conscious  dazed  unconscious
15. If you lost consciousness, how long? \_\_\_\_\_  
Did you go to the hospital?  Yes  No
16. If yes, when?  right after the injury  next day  other \_\_\_\_\_  
Name of hospital \_\_\_\_\_ Name of doctor \_\_\_\_\_  
Diagnosis \_\_\_\_\_  
Treatment Received \_\_\_\_\_
17. If yes, how did you get there?  ambulance other: \_\_\_\_\_
18. If by ambulance, did the ambulance attendants place you in a:  neck brace  
 back brace  other \_\_\_\_\_
19. Was any medication or medical supplies given?  Yes  No If yes, list:  
\_\_\_\_\_

20. Did you have x-rays taken at the hospital?  Yes  No
21. Are you diabetic?  Yes  No
22. Do you have high blood pressure?  Yes  No
23. Do you have arthritis or degenerative joint disease?  Yes  No
24. List all prescription and non prescription medications you take on a regular basis:

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25. Are you presently under treatment for any condition?  Yes  No \_\_\_\_\_

26. Who is your primary care doctor: name, address and phone: \_\_\_\_\_

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27. Do You Smoke?  Yes  No Drink Alcohol?  Yes  No

28. Did you have any physical complaints **Just before the injury**?  Yes  No

29. If yes, what physical symptoms did you have **just before the injury**? \_\_\_\_\_

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30. What type of work do you do? \_\_\_\_\_

31. What are your job requirements? \_\_\_\_\_

32. Have you lost any days of work because of this injury?  Yes  No

33. If yes, give dates: \_\_\_\_\_

### ACTIVITIES OF DAILY LIVING

34. Do you notice any of your **HOME** activities that are different **now** from than **before** the injury?  No. If YES, list them as: (please be very specific)

Those activities that you are now unable to do are: \_\_\_\_\_

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Those activities that are now painful to do are: \_\_\_\_\_

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Those activities that are now difficult to do are: \_\_\_\_\_

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Is there anything else we should know? \_\_\_\_\_

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Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Print Name \_\_\_\_\_

## PERSONAL INJURY INSURANCE COVERAGE

Pt. Name: \_\_\_\_\_ Number \_\_\_\_\_ Date \_\_\_\_\_

Insurance Company \_\_\_\_\_

Address \_\_\_\_\_

Name of adjuster handling claim \_\_\_\_\_

Spoke With \_\_\_\_\_ Time: \_\_\_\_\_ AM / PM

Phone Number \_\_\_\_\_ Date of Accident \_\_\_\_\_

Insured Name \_\_\_\_\_

Claim Number \_\_\_\_\_ Policy Number \_\_\_\_\_

Has the accident been reported?  Yes  No

Will company accept assignment of benefits?  Yes  No

If not, will they make checks payable to patient and our practice?  Yes  No

Limits: How much? \$ \_\_\_\_\_ What's left? \_\_\_\_\_

## GROUP HEALTH INSURANCE

Your Medical insurance Company: \_\_\_\_\_

Address \_\_\_\_\_

Phone Number \_\_\_\_\_ Policy# \_\_\_\_\_

Insured Name \_\_\_\_\_

Agent \_\_\_\_\_ Phone \_\_\_\_\_

## ATTORNEY INFORMATION

Date \_\_\_\_\_ Spoke With \_\_\_\_\_ Number \_\_\_\_\_

Patient Name \_\_\_\_\_

Attorney Name \_\_\_\_\_

Address \_\_\_\_\_

Phone Number \_\_\_\_\_

Does attorney need copies of bills?  Yes  No

In the event of settlement, will they protect any unpaid balance?  Yes  No

Do they have PIP?  Yes  No Do we file?  Yes  No

Do they have insurance?  Yes  No Do we file?  Yes  No

Can we file liability?  Yes  No