

PERSONAL INJURY QUESTIONNAIRE Non- Automobile or Workers Compensation

Please complete this entire form.

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? Yes No

If Yes, please give name and address: _____

13. Immediately after the injury were you: conscious dazed unconscious

14. If you lost consciousness, how long? _____

15. Did you go to the hospital? Yes No

If yes, when? Right after the injury Next day Other _____

Name of hospital _____ Name of doctor _____

Diagnosis _____

Treatment Received _____

16. If you went to the hospital how did you get there? Ambulance Other: _____

17. If by ambulance, did the ambulance attendants place you in a:

neck brace back brace other: _____

18. Was any medication or medical supplies given? Yes No

If yes, please list: _____

19. 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:

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

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

27. Do you smoke? Yes No Do you drink alcohol? Yes No

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

If yes, what physical symptoms did you have? _____

29. What type of work do you do? _____

30. What are your job requirements? _____

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

If yes, give dates: _____

ACTIVITIES OF DAILY LIVING

32. Do you notice any of your **HOME** activities that are different **now** than **before** the injury?

Yes No

If YES, please list: (please be very specific)

Those activities that you are now unable to do are: _____

Those activities that are now painful to do are: _____

Those activities that are now difficult to do are: _____

Is there anything else we should know? _____

Patient Signature _____ Date _____

Print Name _____

PERSONAL INJURY INSURANCE COVERAGE

Patient's 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