

PERSONAL INJURY QUESTIONNAIRE

You have been injured due to an accident. In order for us to effectively treat your injuries, and manage and ultimately help settle your personal injury case, we must have your assistance. Although it may appear to be long and complicated, each question is important to your case in the long run. As such, please take the time to answer each and every question contained herein. If you need more space for comments, use the back side of the page or attach additional pages. Please be patient in filling out this questionnaire and answer each question fully and accurately. Success in your case depends on knowing as much as possible about your medical history and your current condition. Thank you very much for your cooperation.

PATIENT INFORMATION

Name _____ Date of Accident _____

AUTOMOBILE INSURANCE POLICY INFORMATION

Do you have Med Pay Coverage with your insurance policy? ___ Yes ___ No ___ Unsure

Your Insurance Company _____ Claims Rep. _____

Policy Holder's Name _____ Policy Number _____

Address _____

Phone Number _____ Claim Number _____

Responsible Party's Name _____ Phone Number _____

Policy Holder's Name _____ Policy Number _____

Policy Holder's Insurance Company _____ Claims Rep. _____

Address _____

Phone Number _____ Claim Number _____

ATTORNEY INFORMATION (___ None)

Name _____ Phone Number _____

Address _____

OVERVIEW

Before the accident, how would you describe your health?

Excellent Good Fair Poor If Fair or Poor, please explain _____

Check all symptoms have you noticed since the accident. **Circle** all symptoms you currently have.

Brain/Neuropsych/MBTI

- | | | |
|--|---|--|
| <input type="checkbox"/> Wanting to be Alone | <input type="checkbox"/> Irritability | <input type="checkbox"/> Agitation |
| <input type="checkbox"/> Sadness or Tearful | <input type="checkbox"/> Mood Swings | <input type="checkbox"/> Feelings of Isolation from Others |
| <input type="checkbox"/> Personality Change | <input type="checkbox"/> Anger | <input type="checkbox"/> Helplessness |
| <input type="checkbox"/> Reduced Confidence | <input type="checkbox"/> Apathy (Don't Care) | <input type="checkbox"/> Flashbacks to Accident |
| <input type="checkbox"/> Impatience | <input type="checkbox"/> Frustration | <input type="checkbox"/> Difficulty Concentrating |
| <input type="checkbox"/> Day Dreaming/Mindless Staring | <input type="checkbox"/> Disoriented | <input type="checkbox"/> Attention Problems |
| <input type="checkbox"/> Difficulty Focusing/Easily Distracted | <input type="checkbox"/> Confused | <input type="checkbox"/> Can't Remember Numbers |
| <input type="checkbox"/> Reading Problems | <input type="checkbox"/> Writing Problems | <input type="checkbox"/> Poor Attention |
| <input type="checkbox"/> Difficulty with Adding/Subtracting | <input type="checkbox"/> Difficulty Learning New Things | <input type="checkbox"/> Difficulty Remembering Things |
| <input type="checkbox"/> Re-Reading Things to Understand | <input type="checkbox"/> Difficulty Making Decisions | <input type="checkbox"/> Difficulty Planning or Organizing |
| <input type="checkbox"/> Sleepiness/Very Tired | <input type="checkbox"/> Dozing during the Day | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Nausea/Vomiting | <input type="checkbox"/> Appetite Change | <input type="checkbox"/> Loss of Taste |
| <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> Constipation | <input type="checkbox"/> Pupils Different Sizes |
| <input type="checkbox"/> Eyes Sensitive to Light | <input type="checkbox"/> Blurry Vision | <input type="checkbox"/> Double Vision |
| <input type="checkbox"/> Difficulty Speaking | <input type="checkbox"/> Balance Problems | <input type="checkbox"/> Dizziness/Room Spins |
| <input type="checkbox"/> Difficulty Walking | <input type="checkbox"/> Change in Sexual Function | <input type="checkbox"/> Cold Sweats |
| <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Buzzing in Ears | <input type="checkbox"/> Ringing in Ears |
| <input type="checkbox"/> Head seems Heavy | <input type="checkbox"/> Fever | <input type="checkbox"/> Headaches |

Orthopedic/Musculoskeletal

- | | | |
|--|---|--|
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Upper Back Pain | <input type="checkbox"/> Lower Back Pain |
| <input type="checkbox"/> "Clunk" Sound in Neck Movements | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Clicking in Jaw |
| <input type="checkbox"/> Pain when Chewing | <input type="checkbox"/> Face Pain | <input type="checkbox"/> Chest Pain |
| <input type="checkbox"/> Bruise/Contusion to _____ | | <input type="checkbox"/> Stomach Pain |
| <input type="checkbox"/> Scrape/Abrasion to _____ | | |
| <input type="checkbox"/> Shoulder Pain: <input type="checkbox"/> Left <input type="checkbox"/> Right | <input type="checkbox"/> Upper Arm Pain: <input type="checkbox"/> Left <input type="checkbox"/> Right | |
| <input type="checkbox"/> Elbow Pain: <input type="checkbox"/> Left <input type="checkbox"/> Right | <input type="checkbox"/> Forearm Pain: <input type="checkbox"/> Left <input type="checkbox"/> Right | |
| <input type="checkbox"/> Wrist Pain: <input type="checkbox"/> Left <input type="checkbox"/> Right | <input type="checkbox"/> Hand Pain: <input type="checkbox"/> Left <input type="checkbox"/> Right | |
| <input type="checkbox"/> Hip Pain: <input type="checkbox"/> Left <input type="checkbox"/> Right | <input type="checkbox"/> Upper Leg Pain: <input type="checkbox"/> Left <input type="checkbox"/> Right | |
| <input type="checkbox"/> Knee Pain: <input type="checkbox"/> Left <input type="checkbox"/> Right | <input type="checkbox"/> Lower Leg Pain: <input type="checkbox"/> Left <input type="checkbox"/> Right | |
| <input type="checkbox"/> Ankle Pain: <input type="checkbox"/> Left <input type="checkbox"/> Right | <input type="checkbox"/> Foot Pain: <input type="checkbox"/> Left <input type="checkbox"/> Right | |

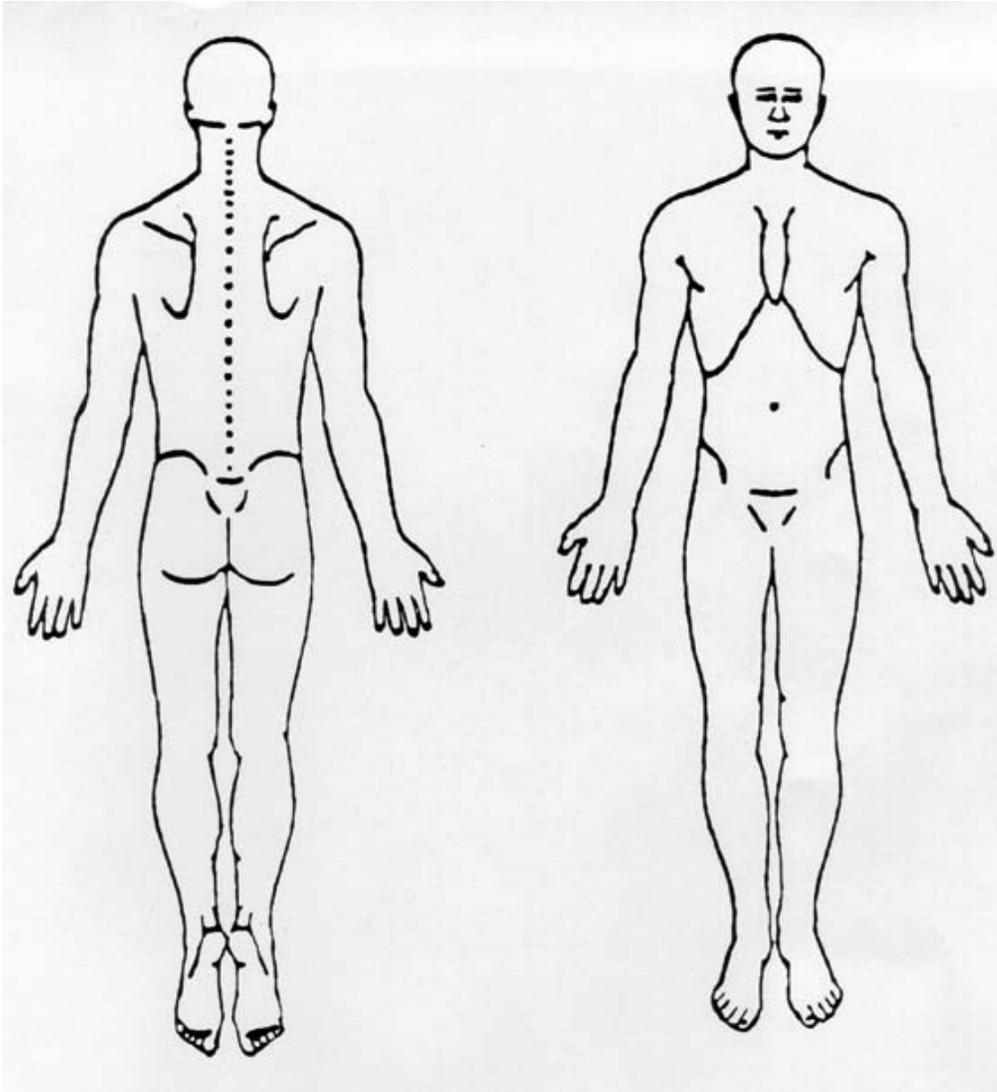
Neurological

- | | |
|--|--|
| <input type="checkbox"/> Numbness/Tingling in Arm/Hand: <input type="checkbox"/> Left <input type="checkbox"/> Right | <input type="checkbox"/> Numbness/Tingling in Leg/Foot: <input type="checkbox"/> Left <input type="checkbox"/> Right |
| <input type="checkbox"/> Weakness of Arm/Hand: <input type="checkbox"/> Left <input type="checkbox"/> Right | <input type="checkbox"/> Weakness of Leg/Foot: <input type="checkbox"/> Left <input type="checkbox"/> Right |

Other Symptoms _____

CURRENT SYMPTOMS ASSESSMENT

Please mark the areas on your body below where you are having pain. Use The 0 - 10 pain scale below.



Pain Scale

(0 - 10)

0-1	= Minimal	= The pain is an annoyance but does not stop me from working.
2-3	= Slight	= I can tolerate the pain but it causes some difficulty in doing my work. However, it does not stop me from working.
5-6	= Moderate	= The pain causes a marked handicap in my ability to work but I can continue.
7-8	= Moderate To Severe	= The pain is approaching the worst I have ever experienced or could imagine. It causes a significant problem with working and most of the time I can't.
10	= Severe	= The pain is the worst I have ever experienced or could imagine and causes me to stop all work and activity.

Sosine/Platto

1. Please indicate your usual level of pain during the past week:

No pain 0 1 2 3 4 5 6 7 8 9 10 **Worst possible pain**

2. Does pain, numbness, tingling or weakness extend into your leg (from the low back) and/or arm (from the neck)?

None of the time 0 1 2 3 4 5 6 7 8 9 10 **All of the time**

3. How would you **rate your general health?** (10-x)

Excellent 0 1 2 3 4 5 6 7 8 9 10 **Poor**

4. If you had to spend the rest of your life with your condition as it is right now, how would you feel about it?

Delighted 0 1 2 3 4 5 6 7 8 9 10 **Terrible**

5. How anxious (e.g. tense, uptight, irritable, fearful, difficulty in concentrating / relaxing) you have been feeling during **the past week:**

Not at all 0 1 2 3 4 5 6 7 8 9 10 **Extremely anxious**

6. How much you have been able to control (i.e., reduce/help) your pain/complaint on your own during **the past week:**

I can reduce it 0 1 2 3 4 5 6 7 8 9 10 **I can't reduce it at all**

7. Please indicate how depressed (e.g. Down-in-the-dumps, sad, downhearted, in low spirits, pessimistic, feelings of hopelessness) you have been feeling in **the past week:**

Not depressed at all 0 1 2 3 4 5 6 7 8 9 10 **Extremely depressed**

8. On a scale of 0 to 10, how certain are you that you will be doing normal activities or working in six months?

Very certain 0 1 2 3 4 5 6 7 8 9 10 **Not certain at all**

9. I can do light work for an hour?

Completely agree 0 1 2 3 4 5 6 7 8 9 10 **Completely disagree**

10. I can sleep at night

Completely agree 0 1 2 3 4 5 6 7 8 9 10 **Completely disagree**

11. An increase in pain is an indication that I should stop what I am doing until the pain decreases.

Completely disagree 0 1 2 3 4 5 6 7 8 9 10 **Completely agree**

12. Physical activity makes my pain worse?

Completely disagree 0 1 2 3 4 5 6 7 8 9 10 **Completely agree**

13. I should not do my normal activities including work with my present pain.

Completely disagree 0 1 2 3 4 5 6 7 8 9 10 **Completely agree**

FUNCTIONAL RATING INDEX: Indicate how your neck and/or back pain has affected your ability to manage your everyday activities. Please answer each section by circling the ONE CHOICE that most applies to you. We realize you may consider that two of the statements in any one section relate to you, but please mark the answer which most closely describes your problem.

- | | | | | | |
|---|--|--------------------------------------|---------------------------------------|--|--------------------------------------|
| 1. Pain Intensity | -----0----- | -----1----- | -----2----- | -----3----- | -----4----- |
| | No Pain | Mild Pain | Moderate Pain | Severe Pain | Worst Possible Pain |
| 2. Sleeping | -----0----- | -----1----- | -----2----- | -----3----- | -----4----- |
| | Perfect Sleep | Mildly Disturbed Sleep | Moderately Disturbed Sleep | Greatly Disturbed Sleep | Totally Disturbed Sleep |
| 3. Personal Care (washing, dressing etc.) | -----0----- | -----1----- | -----2----- | -----3----- | -----4----- |
| | No Pain
No restrictions. | Mild Pain
No restrictions. | Moderate Pain
Need to go slowly. | Moderate Pain
Need some assistance. | Severe Pain
Need 100% assistance. |
| 4. Travel (Driving, etc.) | -----0----- | -----1----- | -----2----- | -----3----- | -----4----- |
| | No Pain on Long Trips | Mild Pain on Long Trips | Moderate Pain on Long Trips | Moderate Pain on Short Trips | Severe Pain on Short Trips |
| 5. Work | -----0----- | -----1----- | -----2----- | -----3----- | -----4----- |
| | Can do usual work plus unlimited work. | Can do usual work but no extra work. | Can do 50% of usual work. | Can do 25% of usual work. | Cannot work. |
| 6. Recreation | -----0----- | -----1----- | -----2----- | -----3----- | -----4----- |
| | Can do all activities. | Can do most activities. | Can do some activities. | Can do a few activities. | Cannot do any activities. |
| 7. Frequency of Pain | -----0----- | -----1----- | -----2----- | -----3----- | -----4----- |
| | No pain. | Occasional pain.
25% of the day. | Intermittent pain.
50% of the day. | Frequent pain.
75% of the day. | Constant pain.
100% of the day. |
| 8. Lifting | -----0----- | -----1----- | -----2----- | -----3----- | -----4----- |
| | No pain with heavy weight. | Increased pain with heavy weight. | Increased pain with heavy weight. | Increased pain with moderate weight. | Increased pain with any weight. |
| 9. Walking | -----0----- | -----1----- | -----2----- | -----3----- | -----4----- |
| | No pain any distance. | Increased pain after 1 mile. | Increased pain after ½ mile. | Increased pain after ¼ mile. | Increased pain with all walking. |
| 10. Standing | -----0----- | -----1----- | -----2----- | -----3----- | -----4----- |
| | No pain after several hours. | Increased pain after several hours. | Increased pain after 1 hour. | Increased pain after ½ hour. | Increased pain with any standing. |
-

INFORMATION ABOUT YOUR ACCIDENT

Date of Accident _____ Time of Accident _____ a.m./p.m.

Were you: Driver Passenger Pedestrian Other _____

What kind of vehicle were you in? _____

What was the other vehicle? _____

How many people were in your vehicle? _____ Were any of them injured? Yes No

If you were a passenger, were you in the: Front Seat Right Rear Seat Left Rear Seat

If you were a pedestrian/other, where were you? _____

Were you wearing a seatbelt? Yes No If yes, what type of seatbelt? 3 Point Lap Belt

Does your vehicle you were in have head rests? Yes No

Where did your accident occur (address or description of location)? _____

Was your vehicle: stopped moving at approximate speed of _____ mph turning left turning right

Did your vehicle strike the other vehicle? Yes No

If no, were you struck by the other vehicle from: Behind Front Left Side Right Side

Approximate speed of the other vehicle _____ mph

Did airbags deploy on impact? Driver Yes No Passenger Yes No

Was your vehicle shoved: forward backward sideways

Did you vehicle go into a spin or roll? Yes No

Were you: shoved forward whipped backward shoved sideways Please explain _____

Did any of your body hit any part of the interior of the vehicle? Yes No If yes, please explain _____

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

Were the police notified? Yes No Was a police report filed? Yes No

In your own words, please describe the accident _____

Please list the body parts injured as a result of your accident: _____

At the moment just prior to impact, were you aware you there was going to be a collision? Yes No

Please explain _____

Did you brace with your hands for impact? Yes No

Did you brace with your feet for impact? Yes No

Body position at the moment of impact: upright leaning forward turning to the rear Other _____

At the moment of impact, were you looking: forward right left up down

Position of your hands (on the wheel, adjusting the mirror, reaching for item, etc.):

Left: _____

Right: _____

Position of your feet (on the brake, on the floor, etc.):

Left: _____

Right: _____

Please describe how you felt:

During the accident _____

Immediately following the accident _____

Later that day _____

The next day _____

HISTORY OF TREATMENT

When did you first seek treatment for this accident? _____

Initially, did you go to a Hospital/Emergency Room? Yes No If no, please continue with **Name of Doctor/Facility** below. If yes, name of Hospital/ER _____ City _____

Were you admitted to the Hospital? Yes No If yes, for how long? _____

Name of doctors at the Hospital/ER who treated you _____

Describe the type of treatment/diagnostic testing you received _____

What did the doctors say was wrong with you? _____

Were you told you would need more treatment? Yes No If yes, were you referred somewhere else? Yes No
If yes, where were you referred and for what? _____

Did the doctors take you off work? Yes No Did the doctor(s) restrict or modify your work? Yes No If yes,
please explain _____

LIST ALL DOCTORS YOU HAVE SEEN REGARDING YOUR ACCIDENT IN THE ORDER THAT YOU SAW THEM (If you have not been treated previously for this injury, proceed to HISTORY OF OTHER INJURIES on page 5.)

Name of Doctor/Facility #1 _____ City _____

Date Treatment Started _____ Date Treatment Ended _____ Number of Visits _____

Type of Doctor (degree or specialty) _____ Describe treatment and/or tests _____

What did this doctor say was wrong with you? _____

Did this doctor take you off work? Yes No Did this doctor restrict or modify your work? Yes No If yes, please explain (include dates) _____

Did this doctor say you would need more treatment? Yes No If yes, please explain _____

Did this doctor refer you anywhere else? Yes No If yes, please explain _____

Are you still treating with this doctor? Yes No If yes, how often? _____

What was the result/outcome of the treatment? _____

Name of Doctor/Facility #2 _____ City _____

Date Treatment Started _____ Date Treatment Ended _____ Number of Visits _____

Type of Doctor (degree or specialty) _____ Describe treatment and/or tests _____

What did this doctor say was wrong with you? _____

Did this doctor take you off work? Yes No Did this doctor restrict or modify your work? Yes No If yes, please explain (include dates) _____

Did this doctor say you would need more treatment? Yes No If yes, please explain _____

Did this doctor refer you anywhere else? Yes No If yes, please explain _____

Are you still treating with this doctor? Yes No If yes, how often? _____

What was the result/outcome of the treatment? _____

Name of Doctor/Facility #3 _____ City _____

Date Treatment Started _____ Date Treatment Ended _____ Number of Visits _____

Type of Doctor (degree or specialty) _____ Describe treatment and/or tests _____

What did this doctor say was wrong with you? _____

Did this doctor take you off work? Yes No Did this doctor restrict or modify your work? Yes No If yes, please explain (include dates) _____

Did this doctor say you would need more treatment? Yes No If yes, please explain _____

Did this doctor refer you anywhere else? Yes No If yes, please explain _____

Are you still treating with this doctor? Yes No If yes, how often? _____

What was the result/outcome of the treatment? _____

Name of Doctor/Facility #4 _____ City _____

Date Treatment Started _____ Date Treatment Ended _____ Number of Visits _____

Type of Doctor (degree or specialty) _____ Describe treatment and/or tests _____

What did this doctor say was wrong with you? _____

Did this doctor take you off work? Yes No Did this doctor restrict or modify your work? Yes No If yes, please explain (include dates) _____

Did this doctor say you would need more treatment? Yes No If yes, please explain _____

Did this doctor refer you anywhere else? Yes No If yes, please explain _____

Are you still treating with this doctor? Yes No If yes, how often? _____

What was the result/outcome of the treatment? _____

Name of Doctor/Facility #5 _____ City _____

Date Treatment Started _____ Date Treatment Ended _____ Number of Visits _____

Type of Doctor (degree or specialty) _____ Describe treatment and/or tests _____

What did this doctor say was wrong with you? _____

Did this doctor take you off work? Yes No Did this doctor restrict or modify your work? Yes No If yes, please explain (include dates) _____

Did this doctor say you would need more treatment? Yes No If yes, please explain _____

Did this doctor refer you anywhere else? Yes No If yes, please explain _____

Are you still treating with this doctor? Yes No If yes, how often? _____

What was the result/outcome of the treatment? _____

If your accident is more than three months old, in the last two months has your condition:

Stayed the same Improved Worsened Fluctuated but overall has stayed about the same

If your condition has worsened, please explain _____

If your condition has improved, please explain _____

Do you feel that your condition will improve with time? Yes No Please explain _____

What treatment(s) have offered you the most relief and how long does/did the relief last? _____

Do you continue to treat yourself? Yes No If yes, please explain _____

Are you currently taking medication to relieve the effects of this injury? Yes No If yes, please explain by listing prescription and non-prescription medications, how often you take them, how much they help, etc. _____

Are you currently using a brace, support, cane, crutch(es), wheelchair, TENS Unit, or other aid due to the effects of your accident? Yes No If yes, please describe the device(s), how often you used and how much relief is offered _____

Have there been any recommendations for diagnostic testing or treatment that you have not received? Yes No If yes, what was the recommendation and who recommended it? _____

HISTORY OF OTHER INJURIES/ACCIDENTS

Have you ever experienced the same or similar symptoms/problems **before** this accident? Yes No If yes, please explain in detail _____

Have you ever had a **prior** auto accidents? Yes No If yes, please explain in detail (including dates) _____

Have you ever had any **prior, injuries not related to this accident** (e.g., sprains/strains, slips/falls, work injuries, etc.) Yes No If yes, please explain _____

Have you had any **new injuries** involving body parts which are a part of your current accident? Yes No If yes, please explain _____

SIGNATURE SECTION

I declare under penalty of perjury that the information provided herein is, to the best of my knowledge, true and accurate.

I personally completed this questionnaire.

I was assisted by _____ in completing this questionnaire for the following reason(s):
(please print)

Signature of Patient

Date

Signature of Person Assisting Patient with Questionnaire, If Applicable

Date