PERSONAL INJURY QUESTIONNAIRE

You have been injured due to an accident. In order for us to effectively treat your injuries, 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

__Wanting to be Alone
__Sadness or Tearful
__Personality Change
__Reduced Confidence
__Impatience
__Day Dreaming/Mindless Staring
__Difficulty Focusing/Easily Distracted
__Reading Problems
__Difficulty with Adding/Subtracting
__Re-Reading Things to Understand
__Sleepiness/Very Tired
__Nausea/Vomiting
__Loss of Smell
__Eyes Sensitive to Light
__Difficulty Speaking
__Difficulty Walking
__Hearing Problems
__Head seems Heavy

__Irritability
__Mood Swings
__Anger
__Apathy (Don't Care)
__Frustration
__Disoriented
__Confused
__Writing Problems
__Difficulty Learning New Things
__Difficulty Making Decisions
__Dozing during the Day
__Appetite Change
__Constipation
__Blurry Vision
__Balance Problems
__Change in Sexual Function
__Buzzing in Ears
__Fever

__Agitation
__Feelings of Isolation from Others
__Helplessness
__Flashbacks to Accident
__Difficulty Concentrating
__Attention Problems
__Can't Remember Numbers
__Poor Attention
__Difficulty Remembering Things
__Difficulty Planning or Organizing
__Fainting
__Loss of Taste
__Pupils Different Sizes
__Double Vision
__Dizziness/Room Spins
__Cold Sweats
__Ringing in Ears
__Headaches

Orthopedic/Musculoskeletal

__Neck Pain
__"Clunk" Sound in Neck Movements
__Pain when Chewing

__Upper Back Pain
__Jaw Pain
__Face Pain

__Lower Back Pain
__Clicking in Jaw
__Chest Pain__Stomach Pain

__Bruise/Contusion to ______________________________
__Scrape/Abrasion to ______________________________

__Shoulder Pain: __Left __Right
__Elbow Pain: __Left __Right
__Wrist Pain: __Left __Right
__Hip Pain: __Left __Right
__Knee Pain: __Left __Right
__Ankle Pain: __Left __Right

__Upper Arm Pain: __Left __Right
__Forearm Pain: __Left __Right
__Hand Pain: __Left __Right
__Upper Leg Pain: __Left __Right
__Lower Leg Pain: __Left __Right
__Foot Pain: __Left __Right

Neurological

__Numbness/Tingling in Arm/Hand: __Left __Right
__Weakness of Arm/Hand: __Left __Right

__Numbness/Tingling in Leg/Foot: __Left __Right
__Weakness of Leg/Foot: __Left __Right

Other Symptoms ____

____

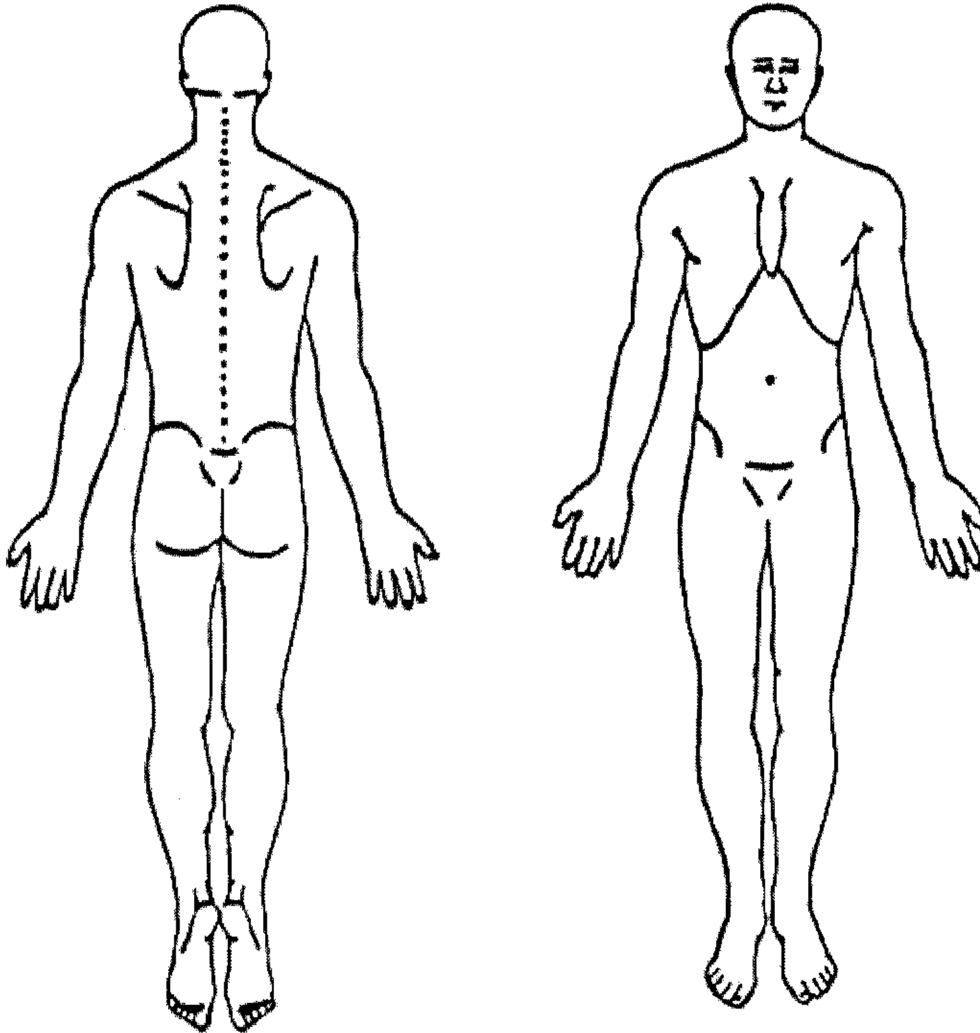
____

____

____

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.

	0	1	2	3	4
1. Pain Intensity	No Pain	Mild Pain	Moderate Pain	Severe Pain	Worst Possible Pain
2. Sleeping	Perfect Sleep	Mildly Disturbed Sleep	Moderately Disturbed Sleep	Greatly Disturbed Sleep	Totally Disturbed Sleep
3. Personal Care (washing, dressing etc.)	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.)	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	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	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	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	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	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	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

Did the 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 approx. 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 the airbags deploy on impact? Driver _____ Yes _____ No; Passenger _____ Yes _____ No

Was your vehicle shoved: __________ Forward ___________ Backward __________ Sideways

Did your vehicle go into a spin or roll? ______ Yes ______ No

Were you: ______ shoved forward _____ whipped backward _______ Shoved sideways

Please Explain: ____

Did any part 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 there was going to be a collision? ____ Yes ____ No

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.): ______________________

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? _______________________________

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____

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 _____

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____

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*** ______