Serving God For

Healthier Generations.

Date: _______________

PERSONAL INJURY QUESTIONNAIRE

Name: ____ (Age) _______ Gender: M F

Home Address: ______________________________________ Home Phone: ( ) __________________________

City, State, Zip: ______________________________________ Work Phone: ( ) _________________________

Email Address: _______________________________________ Cell Phone: ( ) __________________________

Birth Date: ______ / ______ / _______ Social Security #: ______ - _____ - ______ Marital Status: S M D W

Names of Children: ____ Ages: _______________

Occupation: ______________________________________ Employer Name: __________________________________

Spouse's Name: ______________________________________ Cell Phone: ( ) __________________________

Spouse's Employer: ____________________________________ Occupation:_________________________________

INSURANCE COMPANY:____

Address of Company: ____

City, State, Zip: ____ Phone: ( ) ______________________________

Claim #:____ Date of Accident: ________________________

REGULAR INSURANCE COMPANY (PLEASE GIVE COPY OF CARD TO FRONT DESK):

INSURANCE COMPANY:____

Address of Company: ____

City, State, Zip: ____ Phone: ( ) __________________________

ID #:_____________________________________Insured Name:: ____

Insured Date of Birth: _____________________________ Insured SS#: ______________________________________

ATTORNEY INFORMATION (IF APPLIES)

Name: ____

Address of Company: ____

City, State, Zip: ____ Phone: ( ) ______________________________

NATURE OF ACCIDENT FOR WORK INJURY

WAS YOUR ACCIDENT DIRECTLY RELATED TO YOUR WORK? ____ YES ____ NO

IN YOUR OWN WORDS, BRIEFLY DESCRIBE THE EVENTS THAT OCCURRED JUST BEFORE AND DURING THE ACCIDENT: ________________________________

____

____

____

____

____

____

NAME OF WHERE THE ACCIDENT OCCURRED: ____________________________

ADDRESS: ____

CITY: ____________________________ STATE: ____________ ZIP ____________________

GENERALLY DESCRIBE YOUR NORMAL JOB DUTIES: ________________________

____

____

SYMPTOMS AND COMPLAINTS

WERE YOU KNOCKED UNCONSCIOUS? _________ YES ________ NO

PLEASE DESCRIBE HOW YOU FELT IMMEDIATELY AFTER ACCIDENT: __________

____

____

WERE YOU TAKEN TO THE HOSPITAL? _______ YES _______ NO

IF YES, HOSPITAL NAME: ____

TREATMENT RECEIVED: ____

WERE XRAYS TAKEN? ____

ARE YOUR WORK ACTIVITIES RESTRICTED AS A RESULT OF THIS INJURY?

______ YES _____ NO

ARE YOU ABLE TO WORK SINCE THIS INJURY? _______ YES _______ NO

IF NO, DATE OF LAST DAY WORKED: ____

PLEASE MARK THE SYMPTOMS THAT ARE A RESULT OF THIS ACCIDENT:

____DIZZINESS	____CHEST PAIN	____JAW PROBLEMS
____MEMORY LOSS	____IRRITABILITY	____ARM/SHOULDER PAIN
____HEADACHES	____FATIGUE	____NUMB HANDS/FINGERS
____BLURRED VISION	____TENSION	____DIFFICULTY SLEEPING
____RINGING IN EARS	____NECK PAIN	____SHORTNESS OF BREATH
____NAUSEA	____BACK PAIN	____LEG PAIN
____NUMB FEET/TOES	____STIFF BACK	____LOSS OF BALANCE

____OTHER:____

IS YOUR CONDITION GETTING WORSE: _______ YES _______ NO

PLEASE DESCRIBE ANY OTHER PERTINENT INFORMATION:

____

IS THERE ANY CHANCE AT THIS TIME THAT YOU ARE PREGNANT?_____________

PATIENT'S SIGNATURE: ____