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:

_____

_____

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 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?** _____

_____

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: _____

_____

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

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