

PERSONAL INJURY QUESTIONNAIRE

Name _____ Phone () _____

Address _____ City _____ State _____ Zip _____

Age _____ Birthdate _____ Sex _____ S/S # _____

Employer's Name _____ Employer's Address _____

Your Ins. Co. _____ Policy # _____ Agent's Name _____

Name on Policy (If other than self) _____ Policy # _____

Responsible Party's Name _____

Address _____ City _____ State _____ Zip _____

Policy Holder's Name _____ Policy # _____

ATTORNEY

Name _____ Phone () _____

Address _____ City _____ State _____ Zip _____

Were there any witnesses? () Yes () No Name(s) _____

NATURE OF ACCIDENT:

1. Date of Accident _____ Time of Day _____
2. Were you: () Driver () Passenger () Front Seat () Back Seat
3. Number of people in your vehicle? _____ Were you wearing seat belts? _____
4. What direction were you headed? () North () East () South () West
on (name of street) _____
5. What direction was other vehicle headed? () North () East () South () West
on (name of street) _____
6. Were you struck from: () Behind () Front () Left side () Right side
7. Approximate speed of your car _____ mph Other car _____ mph
8. Were you knocked unconscious? () Yes () No If yes, for how long? _____
9. Were police notified? () Yes () No
10. In your own words, please describe accident: _____

11. Did you have any physical complaints BEFORE THE ACCIDENT? () Yes () No If yes, please describe in detail:

12. Please describe how you felt:
 - a. DURING the accident: _____
 - b. IMMEDIATELY AFTER the accident: _____
 - c. LATER THAT DAY: _____
 - d. THE NEXT DAY: _____

