AFFILIATED NEUROLOGY CENTER

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PERSONAL INJURY QUESTIONNAIRE

Name ____ Phone ________________________________

Address _________________________________ City _______________State _______ Zip _______________

Age ______ Birth Date ___________ Sex _______________ S/S# _________________________________

Employer's Name and Address ____

Your Ins. Co. _____________________ Policy # ________________ Agent's Name __________________

Name on Policy (if other than self) ______________________________ Policy # ________________________

Responsible Party Name _____________________________________ Phone ( ) ______________________

Address ___________________________ City _____________________ State _________ Zip _____________

Policy Holder's Name ____ Policy # _________________________

Attorney name ____ Phone ( ) _______________________

Address __________________________ City _______________ State __________ Zip ___________________

Date of Injury ____ Time of Day ____________________________

Were there any witnesses? ☐ Yes ☐ No Names____

DESCRIPTION OF THE ACCIDENT

1. Were you the … ☐ Driver ☐ Front Seat Passenger ☐ Back Seat Passenger ☐ Other
2. Number of people in your vehicle ________ Were you wearing seat belts? ☐ Yes ☐ No
3. Which direction were you headed? ☐ North ☐ East ☐ South ☐ West
   Name of street ____________________________
4. Which direction was the other vehicle headed? ☐ North ☐ East ☐ South ☐ West
   Name of street ____________________________
5. Were you struck from … ☐ Behind ☐ Front ☐ Left Side ☐ Right Side
6. Approx. speed of your car ______ mph. Approx. speed of the other car ________ mph.
7. Were you rendered unconscious? ☐ No ☐ Yes **If Yes, for how long?** ___________________________
8. Was police notified? ☐ Yes ☐ No

In your own words, please describe the incident ____

____

____

____

Where were you taken immediately after the injury? ____

Have you been treated by another doctor since the injury? ☐ No ☐ Yes **If Yes, please provide:**

a) Doctor's name and address ______________________________

b) Type of treatment received ______________________________

Please describe how you felt:

a) DURING the incident ______________________________

b) IMMEDIATELY FOLLOWING the injury ______________________________

c) LATER THAT DAY: ______________________________

d) THE FOLLOWING DAYS: ______________________________

e) Since this injury, are your symptoms ☐ Improving ☐ Getting Worse ☐ Same

What are your PRESENT complaints and symptoms? ______________________________

____

CHECK SYMPTOMS YOU HAVE NOTICED SINCE THE INJURY:

☐ Headache	☐ Loss of Smell	☐ Neck Pain	☐ Feet Feel Cold
☐ Nervousness	☐ Loss of Taste	☐ Neck Stiffness	☐ Pain at Elbows
☐ Fainting	☐ Loss of Memory	☐ Pins & Needles in Arms	☐ Pain at Knees
☐ Lights Bother Eyes	☐ Loss of Balance	☐ Numbness in Fingers	☐ Pain at Heels
☐ Irritability	☐ Ringing in Ears	☐ Pins & Needles in Legs	☐ Pain at Wrists
☐ Depression	☐ Dizziness	☐ Back Pain	☐ Pain at Shoulders
☐ Loss of Sleep	☐ Confusions	☐ Pain in the Legs	☐ Urinary Incontinence
☐ Nightmares			

Have you lost time from work as a result of this injury? ☐ No ☐ Yes **If Yes, please provide**:

a) Last day worked ______________________________

b) Type of employment ______________________________

c) Present Salary ______________________________

d) Are you receiving compensation for time lost from work? ☐ No ☐ Yes **If Yes, please state type of compensation you are receiving** ______________________________

Do you have any congenital (from birth) illnesses which aggravated during this accident? ☐ No ☐ Yes **If Yes, please describe** ______________________________

Do you have any illnesses which aggravated during this accident? ☐ No ☐ Yes **If Yes, please describe:**

____

Have you ever been involved in an accident before? ☐ No ☐ Yes **If Yes, please describe (include Date, type of accident, and injury sustained for each incident)** ______________________________

____

Other pertinent information, including list of your past medical conditions: ______________________________

____

______________________________ ______________________________

PATIENT'S SIGNATURE DATE