PETERSON CLINIC

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PERSONAL INJURY QUESTIONNAIRE

NAME: _____ Date of Birth: _____ PHONE #: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

Employer's Name: _____ Employer's Address: _____

YOUR Insurance Co: _____ Policy #: _____ Agent's Name: _____

DRIVER/ Other Vehicle: _____ Ins Co: _____ Policy #: _____

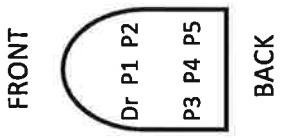
CLAIM # (for this accident): _____

Have you retained an Attorney?: ( ) YES ( ) NO Name: _____

Were there any witnesses? ( ) YES ( ) NO Names: _____

NATURE OF ACCIDENT:

1. Date of Accident _____
2. Indicate on drawing where you were sitting and the direction of impact:



3. Number of people in your vehicle? _____ In other vehicle? _____
4. What direction were you headed? ( ) North ( ) East ( ) South ( ) West
   Name of street: _____
5. What direction was the other vehicle headed? ( ) North ( ) East ( ) South ( ) West
   Name of street: _____
6. Did your head hit: ( ) Head rest ( ) Windshield ( ) Steering Wheel ( ) Roof ( ) Flying Objects ( ) Other
7. At the moment of impact were you (mark all that apply): ( ) Wearing your seat belt ( ) Braking
   ( ) Wearing lap belt ( ) Bracing for impact ( ) Aware accident would happen
8. At the moment of impact was your head: ( ) Turned to the **Left** ( ) Turned to the **Right** ( ) **Straight** ahead
9. At the moment of impact what was your sitting position:
   ( ) Knees Left ( ) Knees Right ( ) Knees straight ( ) Torso turned
10. Other injuries: ( ) Knee ( ) Leg ( ) Ankle ( ) Foot ( ) Hip ( ) Other
11. Were you knocked unconscious? ( ) YES ( ) NO
    If Yes, for how long? _____
12. Were Police notified? ( ) YES ( ) NO
13. In your own words, please describe the accident: _____
    _____
    _____
14. Did you have any physical complaints BEFORE THE ACCIDENT? ( ) YES ( ) NO
    If yes, Please describe in detail: _____
    _____
    _____

15. Please describe how you felt :
    A: **DURING** the accident _____
    B: **IMMEDIATELY AFTER** the accident:_____
    C: **LATER** THAT DAY: _____
    D: **THE NEXT DAY**: _____
16. What are your PRESENT complaints and symptoms? _____
    _____
    _____
17. Do you have any congenital (from birth) factors which relate to this problem? ( ) YES ( ) NO
    If Yes, Please describe: _____
18. Do you have any previous illnesses which relate to this case? ( ) YES ( ) NO
    If Yes, Please describe: _____
19. Have you ever been involved in an auto accident before? ( ) YES ( ) NO
    If Yes, Please describe including date(s) and type(s) of accidents, as well as injury(ies) received: _____
    _____
    _____
20. Where were you taken after the accident:_____
21. Have you been treated by another Doctor since the accident? ( ) YES ( ) NO
    If Yes, Please list Doctor's name and address: _____
22. Since this injury occurred, are your symptoms: ( ) Improving ( ) Getting Worse ( ) the Same
23. CHECK SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT:

☐ Headache	☐ Irritability	☐ Numbness in Toes	☐ FaceFlushed	☐ Feet Cold
☐ Neck Pain	☐ Chest Pain	☐ Shortness of Breath	☐ Buzzing in ears	☐ Hands Cold
☐ Neck Stiff	☐ Dizziness	☐ Fatique	☐ Loss of Balance	☐ Stomach upset
☐ Sleeping Problems	☐ Head Seems Too Heavy	☐ Depression	☐ Fainting	☐ Constipation
☐ Back pain	☐ Pins & Needles in Arms	☐ Light Bothers Eyes	☐ Loss of smell	☐ Cold Sweats
☐ Nervousness	☐ Pins & Needles in Legs	☐ Loss of Memory	☐ Loss of taste	☐ Fever
☐ Tension	☐ Numbness in fingers	☐ Ears Ring	☐ Diarrhea	☐ _____

    Any Symptoms OTHER than above:_____
24. Have you lost time from work as a result of this accident? ( )YES ( )NO
    If Yes, Please complete these questions:
    A- Last Day Worked: _____
    B- Type of Employment: _____
    D- Are you being compensated for time lost from work? ( ) YES ( ) NO
    If Yes, please state type of compensation you are receiving:_____
    _____
25. Do you notice any activity restrictions as a result of this injury: ( ) YES ( ) NO
    If yes, please describe in detail: _____
    _____
    _____
26. Any other important information relating to this accident: _____
    _____
    _____

_____ _____
Today's Date Patient's Signature