BROWN, TARLOW, BRIDGES, PALMER & STONE, PC

This form is subject to attorney-client privilege and work product

Personal Injury Questionnaire

Name: _____ DOB: _____ Today's Date: _____

Height: _____ Weight: _____ Handedness: ___ **Right** ___ **Left**

SSN: _____

Do you receive **Medicare or Medicaid** benefits? ___**Yes** ___**No** If **yes**, which? ___**Medicare** ___**Medicaid**

Accident Date: _____ Time: _____ am / pm

Injury Detail

Were you the: ___ **Driver** ___ **Passenger** ___ **Pedestrian**

If **Driver**, were your hands on the steering wheel? ___ **Right** ___ **Left** ___ **Both**

If **Passenger**, were you in the: ___ **Front seat** ___ **Right rear seat** ___ **Left rear seat**

Seat belt worn at time of impact: ___ **Yes** ___ **No** Was seat belt: ___ **3-point** ___ **Lap only**

Does your vehicle have **head rests?** ___**Yes** ___**No** Location: ___**Head** ___**Neck** ___**Below neck**

Were you aware that the accident was going to happen? ___**Yes** ___**No**

Did you **brace for impact?** ___**Yes** ___**No**...if **yes:** ___braced w/**hands** ___braced w/**feet**

At the time of impact were you: ___**looking straight** ___**looking to right** ___**looking to left**

___**looking down** ___**looking up**

Did **your vehicle** strike the other vehicle?: ___**Yes** ___**No** **OR** were **you struck by them?** ___**Yes** ___**No**

Did **airbags deploy** on impact? ___**Yes** ___**No**

Was the **impact** from: ___**right center** ___**right rear** ___**left rear** ___**right side** ___ **front center**

___**front right** ___**right front** ___**left front** ___**left side**

Was your vehicle in: ___**park** ___**neutral** ___**in gear** ___**moving** ___**stopped**

Did the vehicle go into a **spin or roll** as a result of the impact? ___**Yes** ___**No**

Were **you** shoved: ___**forward** ___**backward** ___**sideways**

Did any other part of **your body hit** the interior of the vehicle? ___**Yes** ___**No**

If **yes**, please specify: ___**seat belt restraints** ___**steering wheel** ___**dashboard** ___**windshield**

___**side door** ___**side window** ___**other**_____

Which **part of your body**: _____

Loss of consciousness: ___**Yes** ___**No** if **yes**, how long? _____

After the accident, did you feel: ___**Disoriented** ___**Dizzy/Dazed** ___**Nervous** ___**Nauseous**

___**Upset** ___**Weak** ___**Other** _____

How **long** did this last? _____

Vehicle Information

Your vehicle: Make / Model / Year: _____ **Your** speed: _____mph

Damage to **your** vehicle: ___**None** ___**Mild** ___**Moderate** ___**Severe** ___**Totaled**

Other vehicle: Make / Model / Year: _____ **Their** speed: _____mph

Damage to **their** vehicle: ___**None** ___**Mild** ___**Moderate** ___**Severe** ___**Totaled**

Do you have **photos?** ___**Yes** ___**No**

Treatment

Did you go to the hospital / Urgent Care? ___**Yes** ___**No**

Name of hospital / Urgent Care: _____

When did you go to hospital / Urgent Care? ___**Following the accident** ___**Next day** ___**Other**_____

How did you get to the hospital / Urgent Care? ___**Ambulance** ___**Police car** ___**Private transportation**

Did you **stay** at the hospital? ___**Yes** ___**No**

If **yes**, how long? ___**Examined/Released** ___**Short Observation** ___**1 Day** ___**Multiple Days**

What **treatment** did you receive? ___**None** ___**Cervical Collar** ___**X-Rays** ___**Stitches** ___**Bandages**

___**Medication:** _____

___**Instructions on Concussions** ___**Instruction on Strains/Sprains**

___**Physical Therapy** ___**Instructed to call a Specialist**

___**Instructed to receive follow up care by a Physician**

Have you **seen additional doctors** as a result of this accident? ___**Yes** ___**No**

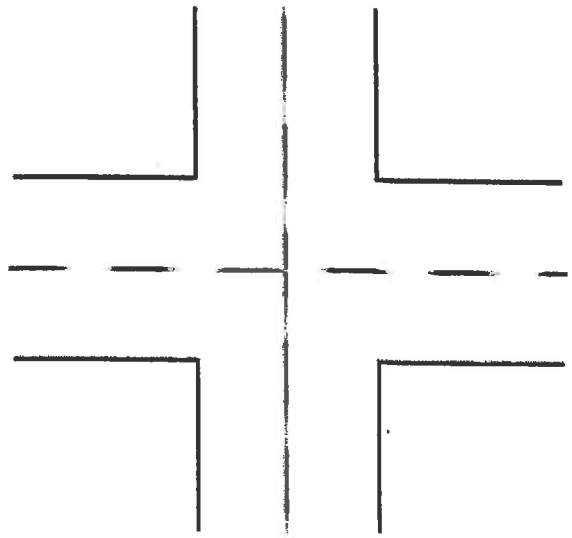
Doctors' names / address and treatment (i.e.: Dr. Smith; Valley Orthopedic; arm brace/medication):

1. _____
2. _____
3. _____

Accident Description

Describe the accident in your own words: _____

Position of Cars



Accident **Location** (Street, Intersection, Highway): _____

Car 1: **Your** car

Car 2: **Their** car

(Add more if needed)

Street Conditions: ___**Dry** ___**Wet** ___**Icy** ___**Fog**

___**Other** _____

Did **police** arrive on the scene? ___**Yes** ___**No**

Were **citations** written? ___**Yes** ___**No**

If **yes**, to who: ___**You** ___**Other Driver** ___**Both**

Have **you** filled out an **accident report**? ___**Yes** ___**No**

Past Medical History

Have you had **previous injuries / accidents?** (Workers Comp / Auto Accident): ___**Yes** ___**No**

If **yes**, explain: _____

Is there any **residual pain from previous injury?** ___**Yes** ___**No**

How much **better** did you feel **prior to current accident?** (i.e. 80%, 100%): _____

Current Medications: _____

_____

Other **significant past** medical history: _____
(Use Additional Pages if Necessary)

Current Complaints

Onset of symptoms: ___**Immediately** ___**Later in day** ___**Later in week**

Since the accident, have your complaints: ___**Improved** ___**Worsened** ___**Unchanged**

Neck / Upper Back

Describe neck / upper back pain: _____

_____

Experienced **headaches** since accident: ___**Yes** ___**No**

If **yes: Intensity:** ___**Mild** ___**Moderate** ___**Severe** **Duration:** ___**Constant** ___**Intermittent**

Specific area (i.e. top of shoulder, etc.) : _____

Mid / Low Back

Describe mid / low back pain: _____

_____

Experienced **leg numbness / weakness:** ___**Yes** ___**No** ___**Right** ___**Left**

If **yes:** Intensity: ___**Mild** ___**Moderate** ___**Severe** Duration: ___**Constant** ___**Intermittent**

Specific area (i.e. little toe, ankle): _____

Other

Experienced **difficulty** in **chewing** or "**popping**" within the **jaw** since accident: ___**Yes** ___**No**

If **yes:** ___**Right side** ___**Left side** ___**Both sides**

Experienced **ringing in ears / loss of balance** since accident: ___**Yes** ___**No**

If **yes: Intensity:** ___**Mild** ___**Moderate** ___**Severe** Duration: ___**Constant** ___**Intermittent**

Experienced **visual abnormalities or disturbances:** ___**Yes** ___**No**

If **yes:** Intensity: ___**Mild** ___**Moderate** ___**Severe** Duration: ___**Constant** ___**Intermittent**

Since the accident have **you felt:** ___**Dizziness** ___**Nervousness** ___**Fatigue** ___**Anxiety**

___**Depression** ___**Excessive irritability** ___**Trouble sleeping** ___**Fear of driving**

___**Loss of concentration** ___**Jaw clenching** ___**Teeth grinding** ___**Other** _____

Best Telephone Numbers to Reach You: _____

Email: _____