



Maximum Health Clinic, P.C.
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PERSONAL INJURY QUESTIONNAIRE

Patient Name: _____ **Today's Date:** _____

Tell me about your accident:

Date of Accident: _____ **Time of Accident:** _____ **Location of Accident:** _____

What were your symptoms immediately after the Accident?

What were your symptoms the next day?

What are your present symptoms?

In addition to the above, check the symptoms that are apparent since the accident:

- | | | | |
|--|--|--|---|
| Back Pain <input type="checkbox"/> | Blurred Vision <input type="checkbox"/> | Clicking in jaw <input type="checkbox"/> | Dizziness <input type="checkbox"/> |
| Eating/Chewing difficulty <input type="checkbox"/> | Fluid in ears <input type="checkbox"/> | Headaches <input type="checkbox"/> | Hip Pain <input type="checkbox"/> Jaw Pain <input type="checkbox"/> |
| Loss of balance <input type="checkbox"/> | Loss of memory <input type="checkbox"/> | Nausea <input type="checkbox"/> | Neck Pain <input type="checkbox"/> |
| Numbness or tingling in arms/hands/fingers (R/L) <input type="checkbox"/> | | Numbness or tingling in legs and/or feet (R/L) <input type="checkbox"/> | |
| Ringing in ears <input type="checkbox"/> | Shoulder Pain <input type="checkbox"/> | Other: _____ | |

How has this accident affected your home life?

How has this accident affected your work?

How many hours/days have you lost from work as a result of this accident?

Have you been able to continue your normal job duties without change? If not, please explain in detail:

Have you had to alter or quit any of your activities that you were able to perform prior to this accident?

Please explain any other life style changes or work changes your have had to do as a result of this accident:

Were you taken to a hospital emergency room?

AUTOMOBILE ACCIDENT QUESTIONS

Describe what you were doing at the moment of impact:

Were you wearing a seat belt? _____ **Were there passengers in your vehicle?** _____

Did you notice your head whip backwards and forwards forcefully?

To the best of your knowledge, what happened to your body at the moment of impact?

Did you hear any popping, cracking or snapping noises in your joints?

Did any part of your body strike the vehicle? (such as knees, arms, chest or head)

Did you have any bruises on your body? _____ **Were you unconscious?** _____ **Stunned?** _____

Were you able to get out of the car under your own power or did you need assistance?

Have you had any blurring of your vision or difficulty seeing at night?
Does light bother your eyes now more than before this accident?
Did the police come to the scene of the accident? Did they file a report? Were there any fatalities?
Were you aware of the impending accident? Road conditions (dry, wet, icy etc.):
What was the make and model of the vehicle that hit you/you hit?
Were they slowing down? Constant speed? Gaining speed? Estimate the other vehicle's speed:
Your auto insurance company: Agent:
Policy #: Other party's auto insurance company:
Their agent: Policy #:
Please diagram where your vehicle and the other vehicle were at the time of the accident:

**TWO LANE
FOUR WAY INTERSECTION**


