Personal Injury Questionnaire

Name:_____Phone: _____

Address:_____City:_____State:_____Zip: _____

Age:_____ Birth Date: _____ Sex: M F SSN: _____

Employer's Name: _____

Employer's Address: _____

Auto Insurance Company:_____I_____

Policy #:_____Agent's Name: _____

Address:_____City:_____State:_____Zip:_____

Name on Policy (if other than _____

Responsible Party's Name: _____

Address:_____City:_____State:_____Zip: _____

Attorney

Name:_____Phone: _____

Address:_____City:_____State:_____Zip: _____

Were there any witnesses? YES NO

Name: _____

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?_____YES_____NO
4. What direction were you headed?_____North_____South_____East_____West
   On (Name of street): _____
5. What direction was the other vehicle headed?_____North_____South_____East_____West
   On (Name of street): _____
6. Were you struck from:_____Behind_____Front_____Left side_____Right side
7. Approximate speed of your vehicle:_____mph Other car:_____mph
8. Were you knocked unconscious?_____YES_____NO
9. Were police notified?_____YES_____NO
10. In your own words, please describe the accident:_____

_____

_____

11. Did you have any physical complaints before the accident?_____YES_____NO

    If yes, Please describe in detail: _____

_____

_____

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