

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

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