PERSONAL INJURY QUESTIONNAIRE

Name: _____ Date: _____

ATTORNEY

Name: _____ Phone: ( )_____

Address: _____ City: _____ State: _____ Zip: _____

NATURE OF ACCIDENT

1. Vehicle Owner: _____ State of Registration: _____

2. Date of accident: _____ Time of day: _____ AM/PM Location (state): RI MA CT Other: _____

3. Were you on WORK TIME at the time of the accident? ( ) Yes ( ) No

If you answered "YES" to the above question, did you file an injury report/work comp claim? ( ) Yes ( ) No

4. Were you the ( ) Driver ( ) Front Seat Passenger ( ) Back Seat Passenger: Right / Middle / Left

5. Number of people in your vehicle: _____

6. Were you wearing seat belts? ( ) Yes ( ) No

7. Was your car equipped with airbags? ( ) Yes ( ) No If yes, did they inflate? ( ) Yes ( ) No

8. Were you struck from: ( ) Behind ( ) Front ( ) Left Side ( ) Right Side

9. Were you knocked unconscious? ( ) Yes ( ) No If Yes, for how long? _____

10. Did police arrive at the scene? ( ) Yes ( ) No 11. Did an ambulance come to the scene? ( ) Yes ( ) No

12. In your own words, please describe the accident: _____

_____

_____

13. Where did you go after the accident? _____

14. Was diagnostic testing or treatment rendered? ( ) Yes ( ) No If YES, describe: _____

_____

15. Have you been examined / treated by another doctor since the accident? ( ) Yes ( ) No

If yes, please list all doctors' names and addresses: _____

_____

What diagnostic procedures or treatment did you receive? _____

16. Have you lost any time from work as a result of the present accident? ( ) Yes ( ) No

If yes, when was your last day at work? _____

Type of employment: _____