Personal Injury Questionnaire

Name_____ Date of Birth_____ Phone_____

Address_____ City_____ State_____ Zip_____

Employer's Name_____ Employer's Address_____

Your Ins. Co. _____ Policy #_____ Agent Name_____

Driver/Other Vehicle_____ Ins. Co._____ Policy # _____

Have you retained an attorney? ( ) Yes ( ) No Name_____

Were there any witnesses? ( ) Yes ( ) No Names_____

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? _____ Other vehicle? _____

4. What direction were you headed? ( ) North ( ) East ( ) South ( ) West
   on (name of street) _____

5. What direction was other vehicle headed? ( ) North ( ) East ( ) South ( ) West
   on (name of street) _____

6. Were you struck from ( ) Behind ( ) Front ( ) Left side ( ) Right side

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

8. Were police notified? ( ) Yes ( ) No

9. In your own words, please describe accident: _____
_____
_____
_____

10. Did you have any physical complaints BEFORE THE ACCIDENT? ( ) Yes ( ) No If yes, please describe in detail: _____
_____
_____
_____

11. Please describe how you felt:
    a. DURING the accident: _____
    b. IMMEDIATELY AFTER the accident: _____
    c. LATER THAT DAY:_____
    d. THE NEXT DAY:_____

12. What are your PRESENT complaints and symptoms? _____

_____

13. Do you have any congenital (from birth) factors which relate to this problem? ( ) Yes ( ) No If yes, please describe:_____

14. Do you have any previous illnesses which relate to this case? ( ) Yes ( ) No If yes, please describe:

_____

15. Have you ever been involved in an accident before? ( ) Yes ( ) No If yes, please describe, including date(s) an type(s) of accidents, as well as injury(ies) received:

_____

_____

_____

16. Where were you taken after the accident? _____

17. Have you been treated by another doctor since the accident? ( ) Yes ( ) No If yes, please list doctor's name and address: _____

18. Since this injury occurred, are your symptoms: ( ) Improving ( ) Getting Worse ( ) Same

19. CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT:

( )Headache	( )Irritability	( )Numbness in toes	( )Face Flushed	( )Feet Cold
( )Neck Pain	( )Chest Pain	( )Shortness of Breath	( )Buzzing in Ears	( )Hands Cold
( )Neck Shift	( )Dizziness	( )Fatigue	( )Loss of Balance	( )Stomach Upset
( )Sleeping Problems	( )Head seems too heavy	( )Depression	( )Painting	( )Constipation
( )Back Pain	( )Pins & Needles in Arms	( )Lights Bother Eyes	( )Loss of Smell	( )Cold Sweats
( )Nervousness	( )Pins & Needles in Legs	( )Loss of Memory	( )Loss of Taste	( )Fever
( )Tension	( )Numbness in Fingers	( )Ears Ring	( )Diarrhea	( )_____

Symptoms other than Above: _____

20. Have you lost time from work as a result of this accident ( ) Yes ( ) No If yes, please complete this question.

A. Last Day Worked: _____
B. Type of Employment: _____
C. Present Salary: _____
D. Are you being compensated for time lost from work? ( ) Yes ( ) No If yes, please state type of compensation you are receiving:_____

21. Do you notice any activity restrictions as a result of this injury? ( ) Yes ( ) No If yes, please describe, in detail:_____

_____

_____

22. What medication did you take: _____
23. Are you still taking medication: _____ How often and how much: _____
24. What were you told was wrong with you: _____

_____

25. Are you doing the same kind of work you were doing at the time of injury:

_____

_____

Patient's Signature _____ Date _____

AGREEMENT TO PAY MEDICAL COST IN THE EVENT OF FAILURE TO PROSECUTE OR IF NO-FAULT CLAIM IS DISALLOWED

MVA CASE NO	POLICY NUMBER	DATE OF INJURY	NATURE OF INJURY	SS#

	Name	Address
CLAIMANT		
EMPLOYER		
INSURANCE CARRIER		

In the event I fail to prosecute the claim for the MVA for this illness or condition or it is determined by the insurance company that the illness or condition is not a result of a compensable auto accident, I _____, hereby agree to pay **Dr. Sharon Ostermeir** located at 2171 Jericho Turnpike, Suite 131 Commack, NY 11725 her usual and customary fees for services rendered to the above named claimant in the above identified case.

Date: _____ Signature_____

If signed by other than claimant, print below: name, address, and relationship of signer.

Name & Address: _____ Relationship: _____