

**Personal Injury Information - Continued**

11. Did you have any physical complaints BEFORE the accident?  Yes  No

Describe: \_\_\_\_\_

12. What are your present complaints which you attribute to the accident? \_\_\_\_\_

\_\_\_\_\_

13. Have you ever been involved in an accident before?  Yes  No If yes, describe the accident, including date, as well as injuries received: \_\_\_\_\_

\_\_\_\_\_

14. Were you taken to a hospital for this present accident?  Yes  No

Name & address of hospital: \_\_\_\_\_

15. Have you been treated by another doctor since the accident?  Yes  No

Name & address of Doctor: \_\_\_\_\_

What type of treatment did you receive? \_\_\_\_\_

16. Since this accident, are your symptoms: ( ) Getting worse ( ) Improving ( ) About the same

17. Have you lost time from work as a result of this accident?  Yes  No

If yes, give last date worked: \_\_\_\_\_ Type of employment: \_\_\_\_\_

Present salary: \_\_\_\_\_ Comments: \_\_\_\_\_

Are you being compensated for time lost from work?  Yes  No Type of Compensation: \_\_\_\_\_

18. What activity restrictions do you notice as a result of this accident? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

19. Other pertinent information or comments: \_\_\_\_\_

\_\_\_\_\_

20. Signature of Patient: \_\_\_\_\_ Date: \_\_\_\_\_