RIVERDALE
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MCDONOUGH
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McDonough, GA 30253
(678) 583-9583
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PERSONAL INJURY QUESTIONAIRE

NAME _____ **DATE:** _____

Accident date: _____ **Type of accident:** ☐ Automobile ☐ Slip and Fall ☐ Work Related

Were you: ☐ Driver ☐ Front Passenger ☐ Right Rear Pass. ☐ Middle Rear Pass. ☐ Left Rear Pass.

Were you wearing a seatbelt? ☐ Yes ☐ No **Did your airbag deploy?** ☐ Yes ☐ No

Were you impacted on the: ☐ Front ☐ Behind ☐ Drivers side ☐ Passenger side

Speed of your car: ☐ Stopped ☐ moving at approx._____ mph **Other cars speed** ___mph

Were you knocked unconscious? ☐ Yes ☐ No **If yes, how long?**_____

Did you get out of the car yourself? ☐ Yes ☐ No **I was helped/taken out by** _____.

After the accident I: (check all that applies)
☐ was taken by ambulance to _____hospital ☐ was examined ☐ had x-rays taken
☐ given a prescription ☐told to follow-up with my doctor ☐ Went home and rested ☐ Went to work
☐ Other _____
_____

How did you feel after the accident:
Just after: ☐Shock ☐Neck pain ☐Mid back pain ☐Low back pain ☐Arm pain ☐Leg pain ☐Headache
Later that day: ☐Neck pain ☐Mid back pain ☐Low back pain ☐Arm pain ☐Leg pain ☐Headache
The next day: ☐Neck pain ☐Mid back pain ☐Low back pain ☐Arm pain ☐Leg pain ☐Headache

Have you missed work due to this accident?

☐ **YES, unable to work in any capacity from** _____ **to** _____.

☐ **YES, able to work part-time with restrictions after this accident.**

☐ **NO, able to work full-time with restrictions after this accident.**

☐ **NO, able to work full-time without restrictions after this accident.**

DO NOT WRITE BELOW THIS LINE

Previous accident or similar injury ?

☐ **NO** ☐ **YES Describe:**_____.

☐ **Treated for this and suffered some residual impairment and disability from it.**

☐ **Treated for this and released with no permanent impairment.**

☐ **Not treated for this injury.**

☐ **No problems immediately prior to this accident.**

Description of this accident: _____
_____
_____
_____
_____
_____