



## PI Questionnaire

DATE: \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_ SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

DATE OF INJURY: \_\_\_\_\_ INSURANCE CASE #'S: \_\_\_\_\_

POLICY #: \_\_\_\_\_ CLAIM #: \_\_\_\_\_

**YOUR VEHICLE TYPE**

YEAR: \_\_\_\_\_ CAR \_\_\_\_\_ STATION WAGON \_\_\_\_\_ VAN \_\_\_\_\_ PICK-UP

MAKE: \_\_\_\_\_ LARGE TRUCK \_\_\_\_\_ BUS \_\_\_\_\_ OTHER: \_\_\_\_\_

**THEIR VEHICLE TYPE**

YEAR: \_\_\_\_\_ CAR \_\_\_\_\_ STATION WAGON \_\_\_\_\_ VAN \_\_\_\_\_ PICK-UP

MAKE: \_\_\_\_\_ LARGE TRUCK \_\_\_\_\_ BUS \_\_\_\_\_ OTHER: \_\_\_\_\_

**YOUR POSITION IN THE VEHICLE**

\_\_\_\_\_ DRIVER \_\_\_\_\_ FRONT PASSENGER  
\_\_\_\_\_ LEFT REAR PASSENGER \_\_\_\_\_ RIGHT REAR PASSENGER

**YOUR VEHICLE AT THE TIME OF THE ACCIDENT WAS...**

\_\_\_\_\_ STOPPED AT A LIGHT \_\_\_\_\_ MAKING A RIGHT TURN \_\_\_\_\_ PROCEEDING ALONG  
\_\_\_\_\_ STOPPED IN TRAFFIC \_\_\_\_\_ MAKING A LEFT TURN \_\_\_\_\_ SLOWING DOWN  
\_\_\_\_\_ STOPPED AT AN INTERSECTION \_\_\_\_\_ PARKING \_\_\_\_\_ ACCELERATING \_\_\_\_\_ OTHER: \_\_\_\_\_

SPEED OF YOUR VEHICLE: \_\_\_\_\_ MPH SPEED OF OTHER VEHICLE: \_\_\_\_\_ MPH

DAMAGE TO YOUR VEHICLE: \_\_\_\_\_ MILD \_\_\_\_\_ MODERATE \_\_\_\_\_ TOALED

DAMAGE TO THEIR VEHICLE: \_\_\_\_\_ MILD \_\_\_\_\_ MODERATE \_\_\_\_\_ TOALED

VISIBILITY AT TIME OF ACCIDENT: \_\_\_\_\_ POOR \_\_\_\_\_ FAIR \_\_\_\_\_ GOOD

ROAD CONDITIONS AT TIME OF ACCIDENT: \_\_\_\_\_ ICY \_\_\_\_\_ WET \_\_\_\_\_ SANDY  
\_\_\_\_\_ DARK \_\_\_\_\_ CLEAR AND DRY

WHO HIT WHAT: \_\_\_\_\_ OTHER VEHICLE HIT YOU \_\_\_\_\_ YOU HIT OTHER VEHICLE

POINT OF IMPACT: \_\_\_\_\_ HEAD ON \_\_\_\_\_ LEFT FRONT \_\_\_\_\_ LEFT REAR  
\_\_\_\_\_ REAR END \_\_\_\_\_ RIGHT FRONT \_\_\_\_\_ RIGHT REAR

**BODY POSITION AT TIME OF ACCIDENT:**

DID YOU SEE THE OTHER VEHICLE COMING? YES/NO  
WERE YOU BRACED FOR THE IMPACT? YES/NO  
DID YOU HAVE YOUR SEATBELT ON? YES/NO  
DID YOU HAVE YOUR SHOULDER HARNESS ON? YES/NO  
DID ANY AIR BAGS DEPLOY? YES/NO → DRIVER/PASSENGER/SIDE  
DOES YOUR CAR HAVE HEADRESTS? YES/NO  
POSITION OF HEADREST: \_\_\_\_\_ EVEN WITH TOP OF HEAD \_\_\_\_\_ EVEN WITH BOTTOM OF HEAD  
\_\_\_\_\_ MIDDLE OF NECK

**DURING THE ACCIDENT:**

DID YOUR BODY STRIKE THE VEHICLE? YES/NO → WHERE? \_\_\_\_\_

DID YOU LOSE CONSCIOUSNESS? YES/NO

DID THE POLICE SHOW UP? YES/NO

WAS A REPORT MADE? YES/NO

WHERE DID YOU GO AFTER THE ACCIDENT? \_\_\_\_\_ HOME \_\_\_\_\_ WORK \_\_\_\_\_ ER \_\_\_\_\_ PRIVATE DOCTOR

HOW DID YOU GET THERE? \_\_\_\_\_ SELF \_\_\_\_\_ SOMEONE ELSE \_\_\_\_\_ AMBULANCE \_\_\_\_\_ POLICE