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MOTORCYCLE INJURY QUESTIONNAIRE

PERSONAL INFORMATION

Name: Date of Birth:
Phone: Work:
Address: City: State: Zip:
Closest Relative: Phone:
SSN#: Driver's License Number:
Employer's Name: Address:
Supervisor's Name: Phone:
Your Insurance Co.: Policy #:
Agent:
Driver/Other Vehicle: Name:
Ins. Co.: Policy #:

Have you ever been involved in an accident before? ( ) Yes ( ) No
If the answer to the above is yes, please describe:

Have you ever been involved in a lawsuit or Worker's Compensation claim before? ( ) Yes ( ) No
If the answer to the above is yes, please describe:

NATURE OF ACCIDENT

Date of Accident: Time: Road Conditions:
Were you: ( ) Operator ( ) Passenger

If you were not the operator, who was?
What is their address and phone number?

Number of People on Motorcycle:

Number of People in Other Vehicle:

Were you struck from ( ) Behind ( ) Front
( ) Left ( ) Right Side

Were you knocked unconscious? ( ) Yes ( ) No

If yes, for how long?

Were police notified? ( ) Yes ( ) No

Was ticket issued? ( ) Yes ( ) No
If yes, to whom?
For What?

Did you take photos? ( ) Yes ( ) No

Were photos taken at the scene? ( ) Yes ( ) No ( ) By Police

Were there any witnesses? ( ) Yes ( ) No
Name(s): Phone Number(s):

In your own words, please describe the accident:

MEDICAL INFORMATION

Did you have any physical complaints BEFORE THE ACCIDENT?
( ) Yes ( ) No

If yes, please describe in detail:

Please describe your injuries FOLLOWING THE ACCIDENT:

What are your PRESENT complaints and symptoms:

Do you have any previous illnesses or other problems which relate to this case? ( ) Yes ( ) No

If the answer to the above is yes, please describe:

When and where did you receive medical treatment following the accident

Additional doctors for accident injuries

Name:

Address:

Name:

Address:

WORK HISTORY

Have you lost time from work as a result of this accident?
( ) Yes ( ) No

If yes, please complete this question:

a. Last Day Worked: How long had you worked there?

b. Type of Employment: How many hours per week?

c. Wage:

d. Are you being compensated for time lost from work?
( ) Yes ( ) No

If yes, please state type and amount of compensation you are receiving:

Do you notice any activity restrictions as a result of this injury?
( ) Yes ( ) No

If yes, please describe in detail:

Other pertinent information:

Date: Client Signature:

FOR ATTORNEY USE:

INSURANCE:	POLICY LIMITS
PIP	
UIM	
UM	
STATUTE OF LIMITATIONS	

STATEMENTS TAKEN:

Name	Date	By Whom
Name	Date	By Whom
Name	Date	By Whom

NOTES: