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**General Personal Injury Questionnaire**

Name of client:

Date of accident or injury:

**A Personal Details**

1. Full Name:
2. Address:
3. Telephone number:  
Work:  
Home:
4. Date of Birth
5. Do you live alone or with a partner?  
Partner's name and relationship
6. Children:  
Name(s)  
Sex:  
Date(s) of birth and age
7. Next friend if child
8. National insurance number

Do you claim a single/married person's tax allowance?

**B Employment details**

9. Professional qualifications and job history



10A (If employed at time of accident) Present or most recent employer

- (a) Employer's name
- (b) Employer's address
- (c) Place of employment
- (d) Date commenced (i) this employment                      (ii) this particular job
- (e) Occupation (job title)

(If self-employed at time of accident)

- (a) Occupation
  - (b) Name of business
  - (c) Address of business
  - (d) Date commenced business
- (If unemployed at time of accident)
- (a) Were you employed immediately prior to the accident?
  - (b) Date of termination of your last job
  - (c) Occupation/profession when employed
  - (d) Name and address of last employer

10B (If employed now)

- (a) Employer's name
- (b) Employer's address
- (c) Place of employment
- (d) Date commenced (i) this employment                      (ii) this particular job
- (e) Occupation (job title)

(If self-employed now)

- (a) Occupation
- (b) Name of business
- (c) Address of business

- (d) Date commenced business  
(If unemployed now)
  - (a) Have you been employed at all since the accident?
  - (b) Date of termination of last job
  - (c) Occupation/profession when employed
  - (d) Name and address of last employer
11. (If employed or previously employed)  
Normal earnings per week prior to accident or in last employment/now
- (a) Gross salary
    - Basic
    - (ii) Overtime
  - (b) Average net take home  
(If self-employed)
  - (a) Average drawings/profit
  - (b) Name and address of accountant
  - (c) Name address and reference of tax office

Please attach copies of your most recent accounts

- 12 Time lost
- (a) Date(s) of time lost from work due to accident
  - (b) Date of return to work
  - (c) Has your job been terminated due to the accident? If so date of termination
  - (d) Have you received any sick pay or health insurance due to your accident?  
If so please set out details

**Please enclose the following documents:**

Curriculum vitae, contract of employment, accounts if self-employed. Wage slips for the last six months prior to the accident and since the accident if employed.

**C. Welfare Benefits**

- 13 Please complete this section if you have received any welfare benefits since the date of the accident (including statutory sick pay):
- (a) Address of local DSS office
  - (b) Amount and description of welfare benefits received (e.g. income support, disability living allowance, statutory sick pay, disability working allowance, mobility allowance, attendance allowance)
  - (c) Address of any job centre from which you claimed unemployment benefit

14. Are you still receiving benefits? Which and how much?

**D. Injuries**

15. Name and address of general practitioner

16. Name and address of hospital(s) where treated

17. Hospital Record Number

18. Name and address of any specialist doctor seen

19. Name and address of any counsellor or social worker

20. Injuries

(a) Nature and extent of injuries (please attach any doctors' reports)

(b) When did the injuries become apparent?

(c) Please enclose photographs of your injuries

(d) Did you lose consciousness during the accident? If so when was this and for how long were you unconscious?

(e) Did you receive any treatment for your injuries?

Where was the treatment received, what was the treatment exactly, for how long were you treated?

Are you still receiving treatment?

21 Duration and prognosis. Are your injuries continuing – if so please describe pain you are now suffering, the treatment you are receiving and the disablement you suffer.

22 If your injuries involve continuing treatment do you know how long this is likely to last either your opinion or a doctor's opinion?

23 Effect of the injuries on you.

(a) Are you now able to work?

When do you think you can return to work?

If you do not think that you can carry out your previous job is there any other job that you would be suitable for?

(b) Are there domestic activities you are unable to undertake due to the accident (e.g. housework gardening or DIY)?

If so have you had to pay another person to do that work or has someone voluntarily taken over that work on your behalf?

(b) Leisure activities you were or are unable to undertake due to the accident.

24 Have you had any injuries or disabilities in the past which may have had an effect on your present condition?

25 Name and address of any disablement resettlement officer who has assisted you.

**Please enclose copies of the following documents:** medical reports, photographs, hospital record card.

## **E Losses and expenses**

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(a) Loss of earnings if not set out above

(b) Clothing or belongings lost or damaged in accident. Please set out details plus replacement costs

(c) Repair costs of vehicle if appropriate/hire costs

(d) Costs of taxis and other travel expenses

(e) Prescription charges or medical costs

(f) Cost of home help or other help

(g) Special equipment necessary or purchased, e.g. modified bath taps, automatic car

(h) Postage and extra telephone bills

(i) Any other losses or expenses

**Please enclose copies of all receipts for the above and do not forget to keep receipts for any expense you incur.**