Auto Accident Questionnaire

Name _____ Today's Date _____

Date of Accident _____ Time of Accident _____ AM PM

Location of Accident _____

Describe how the accident happened in your own words: _____

_____

_____

_____

Where you the [ ] Driver [ ] Passenger [ ] Pedestrian?

If passenger, were you sitting in the [ ] Front [ ] Right Rear [ ] Left Rear? [ ] Other ?_____

Were you wearing a seat belt? [ ] Yes [ ] No

Did your airbag deploy? [ ] Yes [ ] No

What position was your headrest in? _____

What kind of vehicle was the other vehicle involved? _____

What kind of vehicle were you in? _____

What was the point of impact on your vehicle? (What part of your car was hit?) _____

Did your vehicle hit other vehicle(s)? [ ] Yes [ ] No Estimated speed of your vehicle at impact? _____ MPH

Was your vehicle hit by another vehicle(s)? [ ] Yes [ ] No Estimated speed of other vehicle at impact? _____ MPH

Where you aware the accident was going to occur? [ ] Yes [ ] No

What direction were you looking upon impact: _____

What direction did your head, neck, and body move during impact: _____

Did any part of your body hit the inside of the vehicle? If so what and where? _____

Where did you go following the accident? _____ How did you get there? _____

Name of Hospital or Clinic: _____ Attended by Dr. _____

Were you x-rayed at the hospital? [ ] Yes [ ] No If so, what was the diagnosis? _____

Were you admitted to the hospital? [ ] Yes [ ] No How long did you stay? _____

What treatment was rendered?

_____

List any other doctors you have seen as a result of this accident:

_____

How much damage was done to your vehicle? [ ] Totaled [ ] Significant Damage [ ] Light Damage [ ] No Damage

How much damage was done to the other vehicle? [ ] Totaled [ ] Significant Damage [ ] Light Damage [ ] No Damage

Have you lost days of work? [ ] YES [ ] NO Dates: _____

Have you lost any time from work because of this accident? [ ] Yes [ ] No

If yes, give days of disability: _____

Totally disabled from _____ to _____ Partially disabled from _____ to _____

Have you returned to work since the accident? [ ] Yes [ ] No

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CHECK THE SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT:

[ ] Headache	[ ] Irritability	[ ] Numbness in toes	[ ] Face flushed	[ ] Feet cold
[ ] Neck pain	[ ] Chest pain	[ ] Shortness of breath	[ ] Buzzing in ears	[ ] Hands cold
[ ] Neck stiff	[ ] Dizziness	[ ] Fatigue	[ ] Loss of balance	[ ] Stomach upset
[ ] Sleeping problems	[ ] Head seems too heavy	[ ] Depression	[ ] Fainting spells	[ ] Constipation
[ ] Back pain	[ ] Pins & needles in Arms	[ ] Light bothers eyes	[ ] Loss of smell	[ ] Cold sweats
[ ] Nervousness	[ ] Pins & needles in Legs	[ ] Loss of memory	[ ] Loss of taste	[ ] Fever
[ ] Tension	[ ] Numbness in fingers	[ ] Ears ring	[ ] Diarrhea	[ ] _____

VEHICLE YOU WERE IN:

Driver _____

Insured: _____

Address: _____

Phone: _____

Auto Insurance Co.: _____

Ins. Co. Address: _____

Adjuster: _____

Phone: _____

Policy #: _____

Claim # _____

OTHER VEHICLE

Driver: _____

Insured: _____

Address: _____

Phone:_____

Auto Insurance Co.: _____

Ins. Co. Address: _____

Adjuster: _____

Phone: _____

Policy #: _____

Claim # _____

Name of your Insurance Company: _____

Policy Number:_____

Name of person at your Insurance Company responsible for injuries: _____

Have you been contacted by an Insurance Adjuster or Company Representative regarding this claim? [ ] YES [ ] NO

Do you have an attorney who has advised you in this case? [ ] YES [ ] NO

Name of Attorney: _____

Address of Attorney: _____

Phone No of Attorney: _____

Patient's Signature: _____ Date: _____