AUTOMOBILE ACCIDENT QUESTIONNAIRE

PLEASE ANSWER ALL QUESTIONS COMPLETELY

Date: _____

Patient: _____ Phone: _____

Sex: _____ Marital Status: _____ Date of Birth: _____

Address: _____

SSN: _____ Occupation: _____ Work Phone: _____

Company Name: _____ Company Address: _____

Please explain in detail how your accident happened? _____

_____

_____

Driver of other vehicle (if any) _____ Date of Birth: _____

Insurance Company: _____ Phone Number: _____

Policy Number: _____-_____ Claim number: _____

Name of person who has made contact with you _____

Name of driver of vehicle in which you were injured (Self or other) _____

Insurance Company: _____ Phone Number: _____

Policy Number: _____ Claim number: _____

Name of person who has made contact with you _____

Have you retained an attorney? [ ] Yes [ ] No [ ] Not Yet

If so, his/her name, address & phone number: _____

Give time and date present injury occurred _____:_____ [ ] AM [ ] PM _____/_____/_____

You were heading? [ ] North [ ] South [ ] East [ ] West on _____ (street or highway)

Number of people in your vehicle _____

Were police notified [ ] Yes [ ] No Did head strike windshield or object? [ ] Yes [ ] No

Were you knocked unconscious? [ ] Yes [ ] No If so, for how long _____

You were struck from? [ ] Behind [ ] Front [ ] Left side [ ] Right side

You were: [ ] Drive [ ] Passenger [ ] Front seat [ ] Back seat [ ] Using seat belts [ ] other protective devices

Did you feel pain immediately after the accident? [ ] Yes [ ] No [ ] Later that day [ ] Next day [ ] other _____

Where were you taken after the accident? _____ Was treatment given? [ ] Yes [ ] No

Was any doctor consulted after the accident? [ ] Yes [ ] No Doctor's diagnosis _____

If so, give doctor's name _____ [ ] D.C. [ ] M.D. [ ] D.O [ ] D.D.S.

How often did you see the doctor? _____ How long did you see the doctor? _____

Have you ever had any complaints in the involved area before? [ ] Yes [ ] No

If so, what were the complaints? _____

Before the injury, were you capable of working on an equal basis with others your age? [ ] Yes [ ] No

Are your work activities restricted as a results of this accident? [ ] Yes [ ] No

Since the injury, are your symptoms [ ] Improving? [ ] Getting worse? [ ] The Same?