# ACCIDENT & INJURY
# REPORT QUESTIONNAIRE

IF YOURS IS AN ACCIDENTAL INJURY, PLEASE ANSWER THE FOLLOWING QUESTIONS.

DATE OF ACCIDENT OR INJURY _____ TIME OF ACCIDENT OR INJURY _____

TYPE OF ACCIDENT OR INJURY ☐ AUTO COLLISION ☐ ON THE JOB INJURY ☐ OTHER _____

WHERE DID ACCIDENT OCCUR? _____

DESCRIBE HOW ACCIDENT OR INJURY HAPPENED IN DETAIL *(VERY IMPORTANT)* _____

IF YOURS WAS AN AUTO ACCIDENT, PLEASE ANSWER THESE QUESTIONS:

WERE YOU: ☐ DRIVER ☐ PASSENGER ☐ PEDESTRIAN ☐ OTHER

DID YOUR CAR STRIKE THE OTHER? ☐ YES ☐ NO DID THE OTHER CAR STRIKE YOURS? ☐ YES ☐ NO

WERE YOU STRUCK: ☐ FROM BEHIND ☐ FROM FRONT ☐ LEFT SIDE ☐ RIGHT SIDE

WERE TRAFFIC CITATIONS ISSUED TO ☐ YOU ☐ DRIVER OF YOUR CAR ☐ DRIVER OF OTHER CAR ☐ NONE

IS INJURY COVERED BY YOUR PERSONAL INSURANCE? ☐ YES ☐ NO

NAME OF YOUR INSURANCE COMPANY _____

POLICY # _____ YOUR INSURANCE AGENT'S NAME _____

IS INJURY COVERED BY OTHER PERSON'S INSURANCE? ☐ YES ☐ NO

NAME OF OTHER PERSON'S INSURANCE COMPANY _____

NAME OF OTHER PERSON'S INSURANCE AGENT _____

NAME OF CLAIMS ADJUSTOR IN THE CASE _____ PHONE _____

NAME OF YOUR ATTORNEY _____ PHONE _____

IF YOURS WAS AN ON-THE-JOB INJURY, PLEASE ANSWER THESE QUESTIONS:

DID YOU REPORT THIS INJURY TO YOUR EMPLOYER? ☐ YES ☐ NO

DID HE (THEY) RECOMMEND CARE AT OUR OFFICE? ☐ YES ☐ NO

ARE YOU ☐ RIGHT OR ☐ LEFT-HANDED?

DESCRIBE, IN DETAIL, YOUR SYMPTOMS IMMEDIATELY FOLLOWING THE ACCIDENT/INJURY. *(VERY IMPORTANT)* _____

DID YOU HAVE ANY OF THE SYMPTOMS BEFORE? ☐ YES ☐ NO. IF YES, WHICH ONES? _____

DESCRIBE ANY NEW SYMPTOMS SINCE ACCIDENT/INJURY _____

HAVE YOU HAD PREVIOUS INJURY TO THE PRESENTLY INJURED AREA? ☐ YES ☐ NO IF YES, HOW DID IT HAPPEN? _____

HAVE YOU LOST ANY TIME FROM WORK? ☐ YES ☐ NO. DATES: FROM _____ THRU _____

LIMITED WORK DATES: FROM _____ THRU _____ DATE RETURNED TO WORK _____

DID YOU REQUIRE HOSPITALIZATION? ☐ YES ☐ NO. DATE ADMITTED _____ DISCHARGED _____

NAME OF HOSPITAL _____

I DO HEREBY CERTIFY, THAT ALL OF MY STATEMENTS ON THIS FORM ARE TRUE, ACCURATE AND COMPLETE.

YOUR SIGNATURE _____

Where were you sitting in the car? _____

Were you wearing a seatbelt and/or shoulder harness? ___seatbelt only ___both ___neither

Were you aware of the impending impact? ___yes ___no

Were you looking: ___straight ahead ___to the left side ___to the right side ___in the rear view mirror

How did you feel immediately following the accident? _____

_____

Did you lose consciousness? ___yes ___no

Did you strike the: ___steering wheel ___dashboard ___windshield ___roof ___other_____

Did you: ___walk away from the crash ___extrication was necessary (describe) _____

_____

Were paramedics called? ___yes ___no

What treatment was given immediatly after the accident? _____

_____

Did you go to: ___the hospital ___a doctor's office

Did you go by: ___ambulance ___a privately owned car (describe) _____

Were you hospitalized? ___yes...how long_____ ___no

What tests were performed (ie. blood test, urinalysis, EMG ) and what were the results of the tests?

_____

_____

_____

Do you know what the diagnosis was? _____

What was the extent of treatment (ie. medications, supports, physical therapy)? _____

_____

_____

What has been the progress of this treatment? _____

_____

_____

Has the condition improved, stayed the same, or worsened (describe)? _____

_____

_____

What symptoms have appeared since the accident? _____

_____

_____

Have you been involved in any other accidents or falls since the auto accident? ___no ___yes (describe)

_____

_____