

AUTO ACCIDENT QUESTIONNAIRE

NAME _____ DATE _____

DATE OF THE ACCIDENT _____ TIME OF ACCIDENT _____ AM or PM

CITY OF ACCIDENT _____ STREET OF ACCIDENT _____

ROAD CONDITIONS AT THE TIME OF THE ACCIDENT _____

DID POLICE COME TO THE SCENE OF THE ACCIDENT? _____

WERE YOU TAKEN TO THE HOSPITAL? _____ IF YES, WHAT IS THE NAME OF
THE HOSPITAL? _____ IN WHAT CITY? _____

WHAT PARTS OF YOUR BODY WERE X-RAYED AT THE HOSPITAL? _____

*THE FOLLOWING QUESTIONS PERTAIN TO YOU, THE PATIENT, AND
THE VEHICLE YOU WERE IN*

WHERE WERE YOU SEATED IN THE VEHICLE? _____

WERE YOU AWARE OF THE APPROCHING COLLISION PRIOR TO IMPACT OR DID THE IMPACT
CATCH YOU BY SURPRISE? _____

DID YOU LOSE CONCIOUSNESS UPON IMPACT? _____ IF YOU DID LOSE CONCIOUSNESS,
ESTIMATE FOR HOW LONG? _____

HOW FAR IS THE TOP OF THE HEADREST OR SEAT BACK FROM THE TOP OF YOUR HEAD
_____ INCHES ABOVE-BELOW

WERE YOU WEARING A SEATBELT? _____ IF YES, THEN WAS IT A LAP BELT
OR A SHOULDER-LAP SEATBELT (circle one)

LIST THE YEAR MAKE AND MODLE YOU WERE IN: _____

WAS YOUR CAR STOPPED AT THE TIME OF IMPACT? _____ IF YES, THEN WAS THE
DRIVER'S FOOT ALSO ON THE BRAKE? _____ IF NO, THEN ESTIMATE THE SPEED OF THE

THE VEHICLE YOU WERE IN: _____ MPH

IF THE VEHICLE WAS MOVING AT THE TIME OF IMPACT, WAS IT SLOWING DOWN? _____
OR WAS IT GAINING SPEED? _____ OR WAS IT TRAVELING AT A STEADY RATE OF
SPEED AT THE TIME OF IMPACT? _____

PLEASE DESCRIBE TO THE BEST OF YOUR KNOWLEDGE, WHAT HAPPENED DURING THIS
ACCIDENT: _____

DESCRIBE YOUR CURRENT SYMPTOMS: _____

HOW LONG AFTER THE ACCIDENT DID EACH OF YOUR SYMPTOMS APPEAR? _____

RIGHT AFTER _____

28-48 HOURS AFTER _____

OTHER _____

HAVE YOU HAD THESE SYMPTOMS BEFORE? _____ WHEN? _____

IF YES, WHAT IS THE DIFFERENCE? _____

DESCRIBE WHAT BLEEDING/ CUTS/ BRUISES YOU GOT DURING THIS ACCIDENT, IF ANY: _____

DID YOUR BODY MAKE CONTACT WITH THE CAR DOOR, HEADREST, STEERING WHEEL, ETC.?

EXPLAIN: _____

WHAT WAS THE COST DAMAGE TO THE VEHICLE YOU WERE IN? _____

WHAT OF THE FOLLOWING CAR PARTS BROKE DURING THE ACCIDENT? (please check)

WIND SHIELD _____ Rt/LT SIDE WINDOW _____ STEERING WHEEL _____

FRONT SEAT BACK _____ OTHER _____

WAS THE TRUNK OF YOUR BODY/ HEAD POINTED STRAIGHT FORWARD AT THE TIME OF THE COLLISION? _____ IF NO, WHICH DIRECTION WAS IT TURNED, AND BY HOW MUCH?

LIST THE OTHER DOCTORS YOU HAVE SEEN AND INDICATE WHAT TREATMENT WAS ADMINISTERED AND THE RESULTS: _____

THE FOLLOWING QUESTIONS PERTAIN TO THE OTHER VEHICLE INVOLVED IN THE ACCIDENT

WHAT IS THE YEAR _____ MAKE _____ MODEL _____ OF THE OTHER VEHICLE?

WAS THE OTHER VEHICLE MOVING AT THE TIME OF THE COLLISION? _____

IF YES, WHAT WAS ITS APPROXIMATE SPEED? _____ MPH

IF THE OTHER VEHICLE WAS MOVING AT THE TIME OF THE COLLISION, WAS IT

SLOWING DOWN? _____ GAINING SPEED? _____

OR TRAVELING AT A STEADY SPEED _____

IF YOU HAVE BEEN IN PREVIOUS AUTO ACCIDENTS, PLEASE LIST THE YEAR EACH WAS IN:

(OVER)

INSURANCE INFORMATION

PATIENT NAME _____ DATE _____

YOUR AUTO INSURANCE COMPANY

NAME _____

ADDRESS _____

POLICY # _____ CLAIM # _____

AGENT _____ PHONE _____

AGENT'S ADDRESS _____

YOUR HEALTH INSURANCE COMPANY

NAME _____

ADDRESS _____

POLICY # _____ GROUP # _____

EMPLOYER _____ PHONE _____

OTHER DRIVER'S AUTO INSURANCE COMPANY

NAME _____

ADDRESS _____

POLICY # _____ CLAIM # _____

AGENT _____ PHONE _____

AGENT'S ADDRESS _____

HAVE YOU RETAINED AN ATTORNEY? _____

IF YES, ATTORNEY'S NAME _____

ADDRESS _____

CITY _____ PHONE _____