

AUTOMOBILE ACCIDENT QUESTIONNAIRE

1. Name _____ Today's date _____
2. Date of accident _____ Time of accident _____ AM/PM
3. Address of accident _____
City & State of accident _____
4. What direction were you heading? _____ Other vehicle was headed? _____
5. Did police come to the accident scene? _____ Were you taken to a hospital? _____
If so, how were you transported? _____
Name and address of the hospital? _____
Were you x-rayed at the hospital? _____
6. Was any other doctor consulted after the accident? _____ Doctor's name? _____
What was the diagnosis? _____ Any treatment given? _____
What type of treatment? _____ How many treatments? _____
7. Please list any other health care providers consulted for this accident. _____

8. Where did you feel pain after the accident? _____
When did you first start to feel this pain? _____
9. Have you ever had complaints in the involved area before? _____
If so, what were the complaints? _____
10. Since this injury, are your symptoms : Improving? _____ Getting worse? _____ Same _____
11. Are your work activities restricted as a result of this accident? _____
What type of activities are required in your normal work day? _____

The following questions pertain to you, the patient, and the vehicle you were in.

1. List the year, make, and model of the vehicle you were in: Year _____ Make _____
Model _____
2. Was your car stopped at the time of impact? _____ If no, what is the estimated speed of the car you were in? _____ mph
3. If the car was moving at the time of impact, was it slowing down ____ ; or was it gaining speed? ____ ; Were there any skid marks? _____
4. Did your car subsequently hit another car? _____ or another object? _____
5. Was your car pushed ahead or in any other direction as a result of impact? _____
6. Where were you seated in the car? Driver _____ passenger _____ front seat _____
back seat _____
7. Were you wearing a seatbelt? _____ If yes, was it a shoulder-lap belt _____ or lap only _____
8. Were you aware of the approaching collision prior to the impact _____ or did the impact take you by surprise? _____
9. Was the trunk of your body pointed straight forward at the time of impact? _____ If no, which direction was it turned and by how much? _____
10. Was your head pointed straight forward? _____ If no, what direction was it turned and by how much? _____
11. How far is the top of the headrest or seat back from the top of your head? (approximately) _____ inches above _____ below _____
12. Did you lose consciousness (blackout) upon impact? _____ If yes, approximately how long? _____

13. Please describe, to the best of your knowledge, what happened during this accident:

13. What is the damage estimate to the car you were in? _____ Do you have photos? _____

14. Which of the following car parts broke in this accident?

Windshield _____ Front seat back _____
Rt / Lt side window _____ Other _____
Steering wheel _____ Other _____

15. What bleeding cuts did you get during this accident? _____

What bruises did you get during this accident? _____

16. On what part of the auto did the following body parts hit?

Head hit _____ Rt / Lt hip hit _____
Chest hit _____ Rt / Lt leg hit _____
Rt / Lt shoulder hit _____ Rt / Lt knee hit _____
Rt / Lt arm hit _____ Other _____

The following questions pertain to the other vehicle involved in the accident:

1. What is the year, make, and model of the other vehicle? Year _____
Make _____ Model _____ Describe damage to the other
vehicle _____ Any other cars involved? _____
2. Was the other car moving at the time of impact? _____ If yes, what was the
approximate speed? _____ mph
3. If the other car was moving at the time of the collision, was it slowing down? _____
gaining speed? _____ Any skid marks? _____

1. Who is your insurance company? (please include address and phone #) _____

2. Did you file a claim? _____ Claim #: _____
3. Adjustor's name _____ Telephone # _____
4. Driver of car in which you were in? (if applicable) _____ Insurance
company? _____ policy # _____
5. Does the driver have a Medical Pay (Med Pay) policy? ___ Amount of policy? _____
Approximate amount left on Med Pay? _____
6. What are the UM/UIM policy limits? _____
7. Driver of the other car? (if applicable) _____
Insurance company? _____ policy # _____
Claims adjustor _____ Telephone #: _____
8. Who received the citation for the accident? _____ For what? _____
9. Have you retained an attorney? _____ If yes, attorney's name and address _____

10. Do you have health insurance? _____ Company ? _____

If you have been in previous auto accidents, please list the year each was in:

1. _____ Injuries sustained? _____ Claims made? _____ Treatment? _____
2. _____ Injuries sustained? _____ Claims made? _____ Treatment? _____

Name printed

Signature

Date