AUTOMOBILE ACCIDENT QUESTIONNAIRE

Please answer all questions completely

Patient ______________________________ Date ______________
SS# ______________ Date of Accident ______________________
Sex _______ Marital Status __________ Date of Birth ______________________
Address ____________________ City ______________ State ______ Zip ______
Home Phone ______________ Business Phone ______________ Cell Phone ______________
Business Name ____________________ Occupation ______________________
Business Address ____________________ City ______________ State _____ Zip __________
Please explain in detail how your accident happened ______________________________
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Name of the driver of the other vehicle (if any) ______________________________
Insurance Company ____
Claim Adjuster's Name ____________________ Phone Number ______________
Policy Number ____________________ Claim Number ______________________
Name of driver of vehicle in which you were injured (self or other) ______________________
Your Insurance Company ____
Claim Adjuster's Name ____________________ Phone Number ______________
Policy Number ____________________ Claim Number ______________________
Do you have Medical Payment on your Automobile Insurance? Yes ______ No ______
Have you retained an attorney? Yes ______ No ______
Attorney's Name ____________________ Phone Number ______________
Attorney's Address ____________________ City ______________ State _____ Zip __________
Location of Accident ____
Number of people in your vehicle? ________ Police Notified? __________
Did any part of your body hit anything in your car? (i.e.: your head on the windshield or steering wheel)______
Explain ____
Were you knocked un-conscious? Yes ______ No ______ If so, how long? ______________
From which direction were you hit? Behind ______ In Front ______ Left Side ______ Right Side ______
Where in the vehicle were you? ____________________ Wearing seat belt? ______________
Other safety devices (i.e. air bags) ____
Did you feel pain immediately after the accident? Yes ______ No ______ Later that day ______ Next day______
Where did you feel the pain after the accident? ______________________________________
Did you receive medical attention after the accident? Yes ______ No ______
Where did you receive treatment? (i.e. Emergency Room, Urgent Care Clinic) ______________________
What was the nature of that treatment? ______________________________________
Did your regular doctor or specialist treat you after the accident? Yes ______ No ______
Give doctors name ____________________ DC _______ MD _______ DO _______ DDS _______
What was the nature of that treatment? ______________________________________
Have you had any previous complaints in the involved area? Yes ______ No ______
If so, what were those complaints? ______________________________________
Are your home or work activities restricted as a result of this accident? Yes ______ No ______
Since the accident/injury are your symptoms, Improving ________ Getting worse _______ The same ________