

# AUTO ACCIDENT QUESTIONNAIRE

## INFORMATION ABOUT YOU

Name \_\_\_\_\_ Phone \_\_\_\_\_  
Cell \_\_\_\_\_ Work \_\_\_\_\_ E-mail \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Age \_\_\_\_\_ Birthdate \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_  
Sex ( ) Male ( ) Female Height \_\_\_\_\_ Weight \_\_\_\_\_  
Employer's Name \_\_\_\_\_ Employer's Address \_\_\_\_\_  
Your Ins. Co. \_\_\_\_\_ Policy # \_\_\_\_\_ Agent's Name \_\_\_\_\_  
Name on Policy (if other than self) \_\_\_\_\_ Policy # \_\_\_\_\_  
Responsible Party's Name \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Policy Holder's Name \_\_\_\_\_

## INFORMATION ABOUT YOUR ATTORNEY

Name \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Were there any witnesses? ( )Yes ( )No Names \_\_\_\_\_

## INFORMATION ABOUT YOUR ACCIDENT

1. Date of accident \_\_\_\_\_ Time \_\_\_\_\_ Number of passengers \_\_\_\_\_
2. Vehicle type: (Year and model) \_\_\_\_\_
3. Were you: ( )Driver ( )Front passenger ( )Left rear seat ( )Right rear seat
4. Your vehicle was: ( )Stopped at intersection ( )Stopped in traffic ( )Stopped at light  
( )Making a right turn ( )Making a left turn ( )Parking ( )Proceeding along ( )Slowing down  
( )Accelerating
5. Your vehicle's speed \_\_\_\_\_ Their vehicle's \_\_\_\_\_
6. Damage to your vehicle \$ \_\_\_\_\_ Damage to their vehicle \$ \_\_\_\_\_
7. Visibility : ( )Poor ( )Fair ( )Good
8. Road condition: ( )Icy ( )Wet ( )Sandy ( )Dark ( )Clean and dry
9. Who hit what? ( )You hit other vehicle ( )Other vehicle hit you ( )You hit object: \_\_\_\_\_
10. Point of impact: ( )Head-on ( )Left front ( )Right front ( )Rear-end ( )Left rear ( )Right rear
11. Did you see accident coming? ( )Yes ( )No Were you braced for the accident? ( )Yes ( )No
12. Did you have a seat belt on? ( )Yes ( )No Did it have a shoulder harness? ( )Yes ( )No
13. Did you have a head rest? ( )Yes ( )No Where was it positioned? ( )Even with top of the head  
( )Even with bottom of head ( )Middle of neck
14. What direction were you facing? ( )Straight forward ( )Left ( )Right
15. Did your body strike the inside of your vehicle? ( )No ( )Yes Describe: \_\_\_\_\_
16. Did you lose consciousness during the accident? ( )Yes ( )No How long? \_\_\_\_\_
17. Did police show up at the scene? ( )Yes ( )No Was there a report filled out? ( )Yes ( )No

18. In your own words, please describe the accident: \_\_\_\_\_

\_\_\_\_\_

19. Did you have any physical complaints BEFORE THE ACCIDENT? ( )Yes ( )No  
If yes, describe: \_\_\_\_\_

\_\_\_\_\_

20. Please describe how you felt:  
a. DURING the accident: \_\_\_\_\_  
b. IMMEDIATELY AFTER the accident: \_\_\_\_\_  
c. LATER THAT DAY: \_\_\_\_\_  
d. THE NEXT DAY: \_\_\_\_\_

21. What are your PRESENT complaints and symptoms? \_\_\_\_\_

\_\_\_\_\_

22. Do you have congenital (from birth) factors which relate to this problem? \_\_\_\_\_

\_\_\_\_\_

23. Do you have any previous illnesses which relate to this case? ( )Yes ( )No  
If yes, please describe: \_\_\_\_\_

\_\_\_\_\_

24. Have you ever been involved in an accident before? ( )Yes ( )No  
If yes, please describe, including date(s) and type(s) of accidents as well as injuries received: \_\_\_\_\_

\_\_\_\_\_

25. Where were you taken after your current accident? \_\_\_\_\_

26. Have you been treated by another doctor since the accident? ( )Yes ( )No  
If yes, names: \_\_\_\_\_

\_\_\_\_\_

27. Since this injury occurred, are your symptoms: ( )Improving ( )Getting worse ( )Same

28. CHECK SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT:

- |                      |                       |                          |                     |                   |
|----------------------|-----------------------|--------------------------|---------------------|-------------------|
| ( ) HEADACHE         | ( ) IRRITABILITY      | ( ) NUMBNESS-TOES        | ( ) FACE FLUSHED    | ( ) FEET COLD     |
| ( ) NECK PAIN        | ( ) CHEST PAIN        | ( ) SHORTNESS-BREATH     | ( ) BUZZING IN EARS | ( ) HANDS COLD    |
| ( ) NECK STIFF       | ( ) DIZZINESS         | ( ) FATIGUE              | ( ) LOSS OF BALANCE | ( ) STOMACH UPSET |
| ( ) SLEEPING PROBLEM | ( ) HEAD IS HEAVY     | ( ) DEPRESSION           | ( ) FAINTING        | ( ) CONSTIPATION  |
| ( ) BACK PAIN        | ( ) PINS/NEEDLES ARMS | ( ) LIGHT SENSITIVE EYES | ( ) LOSS OF SMELL   | ( ) COLD SWEATS   |
| ( ) NERVOUSNESS      | ( ) PINS/NEEDLES LEGS | ( ) LOSS OF MEMORY       | ( ) LOSS OF TASTE   | ( ) FEVER         |
| ( ) TENSION          | ( ) NUMBNESS-FINGER   | ( ) EARS RING            | ( ) DIARRHEA        | ( ) _____         |

Symptoms other than above \_\_\_\_\_

29. Have you lost time from work as a result of this accident? ( )Yes ( )No  
a. Last day work: \_\_\_\_\_

b. Type of employment: \_\_\_\_\_

c. Present salary: \_\_\_\_\_

d. Are you being compensated for time lost from work? ( )Yes ( )No

If yes, type of compensation you are receiving: \_\_\_\_\_

30. Do you notice any activity restriction as a result of this injury? ( )Yes ( )No

If yes, please describe: \_\_\_\_\_

\_\_\_\_\_

31. Other pertinent information: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient's Signature