

Auto Accident Questionnaire

Accident Information

Date of Accident: _____ Number of People in Accident Vehicle _____ Name of Driver (if not you) _____

Were you the: Diver / Front Passenger / Rear Passenger – Behind driver / Middle/ Behind Passenger / 2nd Row / 3rd Row?

Year/ Make/ Model of Vehicle you were in: _____

Where was your vehicle impacted? Front / Rear / Driver side / Passenger side

Were you wearing a seatbelt? Yes / No Is the vehicle equipped with airbags? Yes / No Did the air bags inflate? Yes / No

During impact, where were you facing? Forwards Backwards Left Right

Did any part of your body strike anything in the vehicle? Yes No (If Yes describe) _____

Did you lose consciousness? Yes / No For how long? _____

Were you: Aware / Surprised by the impact?

In your own words, please describe the accident in detail: _____

Before the Accident

Have you ever had complaints in the involved area: Yes No

If yes, were they present at the time of the accident? Yes No (describe) _____

Were you able to work without restrictions before the accident? Yes No

At the time of the Accident

Did you feel pain immediately after the accident? Yes No (If No, When?) Later that Day Next day When? _____

Did you go to a Hospital or see any other doctor? Yes No (If Yes, Where?) _____

How did you get there? Ambulance / Private Transportation / Other: _____

Were any x-rays taken? Yes No Was any medications Prescribed to you? Yes No

Since the Accident

Are your symptoms: Getting better Staying the same Getting worse

Have you missed any time from work since the accident? Yes No (If yes, How many days?) _____

If no, Is the pain restricting you from performing your job duties? Yes No

Legal Information

Did the police arrive at the scene? Yes No Was a police report filed? Yes No

Attorney Name: _____ Attorney Number: _____

Your Auto Insurance Company _____ Policy # _____

Other Auto Insurance Company _____ Policy # _____

I have answered these questions to the best of my knowledge and certify them to be true and correct.

Patient or Guardian Signature _____ Date: _____

Print Name: _____