AUTOMOBILE ACCIDENT QUESTIONNAIRE

Please answer all questions completely

Name:______________________________ Patient #:______________

Your Auto Insurance Co.______________________ Policy No.______________
Name of your Insurance adjustor______________________ Claim No.______________

Driver of other vehicle (if any)
Name______________________ Insurance Company______________ Policy No.______________

Driver of vehicle in which you were injured
Name______________________ Insurance Company______________ Policy No.______________

What was the time and date of the accident?______________________________

Please explain in detail how your accident happened (include location)______________________________
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Have you retained an attorney? ☐ Yes ☐ no
If so, his/her name/address/phone number______________________________

Were police notified? ☐ Yes ☐ No If yes, what police department was it?______________________________

Were you knocked unconscious? ☐ Yes ☐ No If so, for how long?______________________________

Were you struck from ☐ Behind ☐ Front ☐ Left Side ☐ Right Side

You were ☐ Driver ☐ Passenger
☐ Front seat ☐ Back seat
☐ Using seat belt ☐ Other protective devices

Was there anyone else in the car with you? ☐ Yes ☐ No If so, were they injured? ☐ Yes ☐ No

Where did you feel pain immediately after the accident?______________________________

Where were you taken after the accident?______________________________

What treatment was given?______________________________

Was any other doctor consulted after your accident? ☐ Yes ☐ No

If so, what was the doctor's name?______________________ ☐ D.C. ☐ M.D. ☐ D.O. ☐ D.D.S.

What was the diagnosis?______________________________

What treatment was given?______________________________

How often did you see the doctor?______________________________

How long did you see the doctor?______________________________

Have you ever had any complaints in the involved area before? ☐ Yes ☐ No

If so what were the complaints?______________________________

Before the injury were you capable of working on an equal basis with others your age? ☐ Yes ☐ No

Are your work activities restricted as a result of this accident? ☐ Yes ☐ No

Since this injury are your symptoms ☐ Improving? ☐ Getting worse? ☐ Same?

Patient Signature:______________________ **Date:**______________