AUTOMOBILE ACCIDENT QUESTIONNAIRE

~ Please answer all questions completely ~

DEAR PATIENT: This information is considered confidential. Please be as neat and accurate as possible. Thank you.

NAME:____________________________ DATE:________________ PATIENT #:__________

Patient's Auto Insurance Co.: ____
Policy #: ______________________________ Claim #: ____________________________
Name Of Your Insurance Adjuster:____
Phone #: ______________________________ Fax #: ______________________________

Name Of Driver Of Other Vehicle : ___________________________ Phone #: ______________
Other Driver Insurance Co.:_________________________________ Phone #: ______________
Insurance Adjuster: ____
Policy #: ______________________________ Claim #: ____________________________

Name of driver of vehicle if you were a passenger:______________________________________
Other driver's insurance company: ____________ Policy #: ____________ Phone #: ____________
Insurance adjuster: ______________________________ Claim #: ___________________________

Have You Retained An Attorney? ( ) Yes ( ) No
Attorney Name: ____ Phone #: ______________

Date Of Accident: ________________ Time Of Accident __________ City & State ______________

You were heading: North (___) South (___) East (___) West (___)
On (street or highway) ____
Other vehicle was heading: North (___) South (___) East (___) West (___)
On (street or highway) ____
Road conditions at the time of accident: Wet (___) Dry (___) Icy (___) Other (___)
Did the police come to the accident scene? Yes (___) No (___)
Were you taken to the hospital? Yes (___) No (___)
If yes, what hospital? ______________________________ How did you get to hospital? ____________
What parts of your body were x-rayed at the hospital? _____________________________________
What treatment was given? ____
What was the diagnosis? ____
Was another doctor consulted after your accident? Yes (___) No (___) Doctor's name:______________
What treatment was given? ____
What was diagnosis? ____

The Following Questions Pertain To You, The Patient And The Vehicle You Were In:

Where were you seated in the vehicle?____
Were you aware of the approaching collision prior to impact, or did the impact catch you by surprise?______________
Did you lose consciousness (black out) upon impact? Yes (___) No (___)
If you did lose consciousness, estimate for how long____________________
How far is the top of the headrest or seatback from the top of your head (approximately) ____inches above / below
Were you wearing a seatbelt? Yes (___) No (___)
If "yes" was it a lap seatbelt or a shoulder-lap seatbelt? ____________________________________
List the year, make, and model of the vehicle you were in: Year______; make ______________; model ____________
Was your car stopped at the time of impact? Yes (___) No (___)
If "yes" was the driver's foot also on the brake? Yes (___) No (___)
If "no" please estimate the speed of the vehicle you were in ____________ m.p.h.

Continued: Questions Pertaining To The Patient And The Vehicle:

If the vehicle was moving at the time of impact, was it: Slowing down? Yes (___) No (___)
Gaining speed? Yes (___) No (___)
Traveling at a steady rate of speed? Yes (___) No (___)

Please describe in detail, to the best of your knowledge, what happened during this accident:

____
____
____
____
____
____
____

What bleeding cuts did you get during this accident? ____
____
What bruises did you get during this accident? ____

On what part of the auto did the following body parts hit:

- Head hit ____
- Chest hit ____
- Right/left shoulder hit ____
- Right/left arm hit ____
- Right/left hip hit____
- Right/left leg hit ____
- Right/left knee hit ____
- Other ____

What is the cost damage to the vehicle you were in? ____

What of the following car parts broke during the accident:

- Windshield (___) Front seat back (___) Right/left side window (___) Steering wheel (___)
- Other: ____

Was the trunk of your body pointed straight forward at the time of collision? Yes (___) No (___)

If "no", which direction was it turned and by how much? ____

The Following Questions Pertain To The Other Vehicle Involved In The Accident:

What is the year, make, and model of the other vehicle?

Year ________ Make ___________________________ Model ___________________________

Was the other vehicle moving at the time of the collision? Yes (___) No (___)

If "yes", what was its approximate speed? _________ m.p.h.

If the other vehicle was moving at the time of collision, was it:

- Slowing down? Yes (___) No (___)
- Gaining speed? Yes (___) No (___)
- Traveling at a steady rate of speed? Yes (___) No (___)