

# AUTOMOBILE ACCIDENT QUESTIONNAIRE

PLEASE ANSWER ALL QUESTIONS COMPLETELY

Date \_\_\_\_\_

Patient \_\_\_\_\_ No. \_\_\_\_\_

Sex \_\_\_\_\_ Marital Status \_\_\_\_\_ Date of Birth \_\_\_\_\_ Home Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State Zip \_\_\_\_\_

Email: \_\_\_\_\_ Occupation \_\_\_\_\_

Who referred you to our office? \_\_\_\_\_

Social Sec. # \_\_\_\_\_ Business Phone \_\_\_\_\_ Company Name \_\_\_\_\_

Company Address \_\_\_\_\_

Please explain in detail how your accident happened? \_\_\_\_\_

Driver of other vehicle (if any) \_\_\_\_\_ Date of Birth \_\_\_\_\_

Insurance Company \_\_\_\_\_ Address \_\_\_\_\_ Phone No: \_\_\_\_\_

Policy No. \_\_\_\_\_

Claim No. \_\_\_\_\_

Name of person who has made contact with you \_\_\_\_\_

Name of driver of vehicle in which you were injured (self or other) \_\_\_\_\_

Insurance Company \_\_\_\_\_ Address \_\_\_\_\_ Phone No: \_\_\_\_\_

Policy No. \_\_\_\_\_

Claim No. \_\_\_\_\_

Name of Person who has made contact with you \_\_\_\_\_

Have you retained an attorney?  Yes  No  Not Yet

If so, his/her name, address & phone # \_\_\_\_\_

Give time and date present injury occurred \_\_\_\_\_  AM  PM \_\_\_\_/\_\_\_\_/\_\_\_\_

You were heading?  North  South  East  West on \_\_\_\_\_ (street or highway)

Number of people in your vehicle \_\_\_\_\_

Were police notified?  Yes  No Did head strike windshield or object?  Yes  No

Were you knocked unconscious  Yes  No If so, for how long \_\_\_\_\_

You were struck from?  Behind  Front  Left Side  Right Side

You were?  Driver  Passenger  Front seat  Back seat  Using seat belts  Other protective devices

Did you feel pain immediately after the accident?  Yes  No  Later that day  Next day  When \_\_\_\_\_

Where did you feel pain immediately after the accident? \_\_\_\_\_

Where were you taken after the accident? \_\_\_\_\_

Was treatment given? \_\_\_\_\_

Was any doctor consulted after the accident?  Yes  No

If so, give doctor's name \_\_\_\_\_  D.C.,  M.D.,  D.O.,  D.D.S.

Doctor's 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 the injury, are your symptoms  Improving?  Getting worse?  The same?