

AUTO ACCIDENT QUESTIONNAIRE

Name: _____ Today's Date _____ Date of Accident _____

Where were you? driver passenger pedestrian
 Struck from? behind right side left side front auto parked
 Did your car strike the others involved? yes no
 Did the other car strike yours? yes no

Accident Location _____ City _____

Road conditions at the time of the accident? wet dry icy other _____

Did the police come to the accident? yes no Do you have a copy of the report? yes no

Who was given a ticket? _____ Who was at fault? _____

Were you wearing a seat belt? yes no If so, Shoulder/Lap Belt _____ or Lap Belt _____

Did you know you were going to be hit before the accident? _____

Did you lose consciousness (black out) upon impact? yes no If so, estimate how long? _____

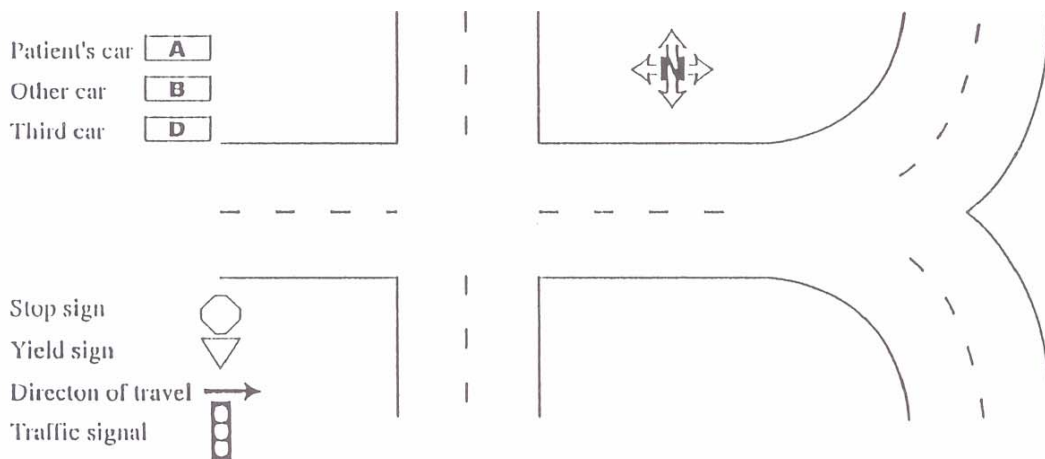
Were you taken to the hospital? yes no If so, were you taken by ambulance? yes no

Have you seen any other medical facilities for your injuries? yes no If so, did they take x-rays yes no

If so, Where? _____ Dr. _____

Were you prescribed any medications? yes no If so, what _____

PLEASE DRAW A DIAGRAM OF THE ACCIDENT



PLEASE WRITE A DESCRIPTION OF THE ACCIDENT

How far was the top of the headrest or seat back from the top of your head?

Approximately _____ inches (Circle One) Above Below

Was your head facing straight forward at the time of the impact? yes no

If no, what direction was it facing and how much? _____

PLEASE CHECK SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Light Bothers Eyes | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Head Seems Too Heavy | <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Feet Cold |
| <input type="checkbox"/> Neck Stiff | <input type="checkbox"/> Pins and Needles in Arms | <input type="checkbox"/> Ears Ringing | <input type="checkbox"/> Hands Cold |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Pins and Needles in Legs | <input type="checkbox"/> Face Flushed | <input type="checkbox"/> Stomach Upset |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Numbness in Fingers | <input type="checkbox"/> Buzzing in Ears | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Numbness in Toes | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Cold Sweats |
| <input type="checkbox"/> Tension | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Fainting | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Depression | <input type="checkbox"/> Loss of Taste | <input type="checkbox"/> _____ |

CAR YOU WERE IN Who was:

Driver of the car you were in? _____ Registered Owner _____

Insurance company? _____ Phone No. _____

Claims Adjuster _____ Claim No. _____

Policy No. _____

Make _____ Model _____ Year _____

What is the estimated damages to the vehicle you were in? \$ _____

What parts of the vehicle were damaged _____

Was your vehicle stopped at the time of impact? yes no

If so, was the driver's foot on the brake? yes no

If no, estimate the speed of the vehicle you were in? _____ mph

If the vehicle was traveling was it: Slowing _____ Gaining Speed _____ Going at steady speed _____

OTHER VEHICLE Who was:

Driver of the other car? _____ Registered Owner _____

Insurance company of the other car? _____ Phone No. _____

Claims Adjuster _____ Claim No. _____

Policy No. _____

Make _____ Model _____ Year _____

What is the estimated damages to the other vehicle? \$ _____

What parts of the vehicle were damaged during the accident: _____

Was the other vehicle stopped at the time of impact? yes no

If no, estimate the speed of the other vehicle? _____ Mph

Do you have an attorney for this case? yes no

If so, Attorney's name _____

Address _____ Phone No. _____

➤ **Patient's Signature** _____ **Date** _____