

## AUTO ACCIDENT QUESTIONNAIRE

Name:	_ Today's Date	Date of Accident
Where were you? ☐ driver Struck from? ☐ behind Did your car strike the others involved? Did the other car strike yours?	☐ right side ☐ yes ☐	pedestrian left □ side □ front □ auto parked no no
Accident Location		City
Road conditions at the time of the acciden	t? $\Box$ wet	$\Box$ dry $\Box$ icy $\Box$ other
Did the police come to the accident?	$\square$ yes $\square$ no	Do you have a copy of the report? $\ \Box$ yes $\ \Box$ no
Who was given a ticket?		Who was at fault?
Were you wearing a seat belt? $\Box$ yes	□ no If so, Sho	oulder/Lap Belt or Lap Belt
Did you know you were going to be hit be	fore the accident? _	
Did you lose consciousness (black out) up	on impact?  yes	$\square$ no If so, estimate how long?
Were you taken to the hospital? $\square$ yes	$\square$ no If so, we	ere you taken by ambulance ? $\square$ yes $\square$ no
Have you seen any other medical facilities	s for your injuries?	yes $\square$ no If so, did they take x-rays $\square$ yes $\square$ no
If so, Where?		Dr.
		o, what
PLEASE D	RAW A DIAGRAN	M OF THE ACCIDENT
Patient's car Other car Third car  Stop sign Yield sign Directon of travel Traffic signal		
PLEASE WRI	ITE A DESCRIPTI	ON OF THE ACCIDENT

How far was the top o Approximately	of the headrest or seat back from inches (Circle One)	ž •		
	raight forward at the time of the im			
	s it facing and how much?			
	-			
PLEASE	CHECK SYMPTOMS YOU HA	VE NOTICED SINCE THE	ACCIDENT	
<ul> <li>□ Headache</li> <li>□ Neck Pain</li> <li>□ Neck Stiff</li> <li>□ Sleeping Problems</li> <li>□ Back Pain</li> <li>□ Nervousness</li> <li>□ Tension</li> <li>□ Irritability</li> </ul>	<ul> <li>□ Dizziness</li> <li>□ Head Seems Too Heavy</li> <li>□ Pins and Needles in Arms</li> <li>□ Pins and Needles in Legs</li> <li>□ Numbness in Fingers</li> <li>□ Numbness in Toes</li> <li>□ Shortness of Breath</li> <li>□ Fatigue</li> </ul>	<ul> <li>□ Light Bothers Eyes</li> <li>□ Loss of Memory</li> <li>□ Ears Ringing</li> <li>□ Face Flushed</li> <li>□ Buzzing in Ears</li> <li>□ Loss of Balance</li> <li>□ Fainting</li> <li>□ Loss of Smell</li> </ul>	<ul><li>□ Cold Sweats</li><li>□ Fever</li></ul>	
☐ Chest Pain	☐ Depression	☐ Loss of Taste		
	Who was: ere in?		·	
	Model		Year	
	amages to the vehicle you were in?			
	e were damaged			
_	ed at the time of impact? $\square$ yes			
If so, was the driver's fo				
	of the vehicle you were in?			
	ing was it: Slowing Gain		ng at steady speed	
ii the vemere was traver	ing was it. Slowing Gan	ming speed Gon	ig at steady speed	
OTHER VEHICLE W Driver of the other car?	/ho was:	Registered Owner		
Insurance company of the other car?		Phone No	·	
Claims Adjuster		Claim No.		
Policy No.				
Make	Model		Year	
What is the estimated da	amages to the other vehicle? \$			
What parts of the vehicle	e were damaged during the acciden	t:		
Was the other vehicle st	opped at the time of impact?	$\square$ yes $\square$ no		
If no, estimate the speed of the other vehicle?		·		
	for this case? $\square$ yes $\square$ no			
Address	ddress Phone No			
Dotion42= 6	Signatura	Data		
F ratient's S	Signature	Date		