Automobile Accident Questionnaire

Accident Information

Name:_____ Date:_____

1. Date of Accident: _____ Time:_____ a.m./p.m.

2. Driver of car: _____ Where you were seated:_____

3. Owner of car: _____ Year and Model of car:_____

4. Visibility at time of accident: poor/fair/good/other: _____

5. Road conditions at time of accident: icy/rainy/wet/clear/dark/other: _____

6. Where was your car struck? right/left/rear/front/side/other: _____

7. Type of accident: ☐ head-on collision ☐ broad-side collision ☐ rear-end collision

☐ front impact, rear-ended car in front ☐ non-collision: _____

8. What part of the car was damaged? _____

9. Describe what happened to you upon impact? _____

10. Did you see the accident was about to happen? ☐ Yes ☐ No

11. Did you brace for impact? ☐ Yes ☐ No

12. Were you wearing a seatbelt? ☐ Yes ☐ No

13. Were you wearing a shoulder harness? ☐ Yes ☐ No

14. Does the car have headrests? ☐ Yes ☐ No

15. If yes, what was the position of your headrest? ☐ top of headrest even with bottom of head

☐ top of headrest even with top of head ☐ top of headrest even with middle of head

16. Was your car braking? ☐ Yes ☐ No Was the other car braking? ☐ Yes ☐ No

17. Was your car moving at the time of the accident? ☐ Yes ☐ No

If yes, how fast would you estimate you were going? _____

18. How fast would you estimate the other car was traveling? _____

19. What was the position of your head and body at the time of impact?

☐ head turned left/right ☐ body straight in sitting position ☐ head looking back

☐ body rotated left/right ☐ head straight forward ☐ other:_____

20. At the time of the accident, recall what parts of your head or body hit what parts of the vehicle:

_____

_____

21. As a result of the accident were you: ☐ rendered unconscious ☐ dazed ☐ other: _____

22. Could you move all parts of your body? ☐ yes ☐ no

If no, why not? _____

23. Were you able to get out of the car and walk unaided? ☐ yes ☐ no

If no, why not? _____

24. Did you have any cuts or bruises from this accident? ☐ yes ☐ no

If so, where? _____

25. Describe how you felt immediately after the accident? _____

_____

How did you feel later that ☐ day ☐ night? _____

How did you feel the next day(s)? _____

26. Check symptoms apparent <u>since</u> the accident:

☐ headache	☐ loss of smell	☐ numbness in fingers	☐ neck pain/stiffness
☐ loss of taste	☐ cold hands	☐ mid-back pain	☐ loss of memory
☐ cold feet	☐ low-back pain	☐ fatigue	☐ diarrhea
☐ tension	☐ constipation	☐ pain behind eyes	☐ shortness of breath
☐ chest pain	☐ dizziness	☐ irritability	☐ nervousness
☐ fainting	☐ depression	☐ cold sweats	☐ anxious
☐ sleeping problems	☐ loss of balance	☐ numbness in toes	
☐ ringing/buzzing in ears		☐ eyes sensitive to light	☐ other:_____

_____

_____

_____

37. Do you have an attorney handling this case? ☐ yes ☐ no

If yes, who? (name/address)_____

_____

Insurance Information

Patient's personal insurance: _____

Insured's name (if other than patient) _____

Policy #: _____

Insurance Company Name: _____

Phone#: _____

Address: _____ City: _____ State/Zip: _____

Claim #: _____ Adjuster's name/phone: _____

_____

Other party's insurance: _____

Insured's name (if other than patient) _____ Policy #: _____

Insurance Company Name: _____ Phone#: _____

Address: _____ City: _____ State/Zip: _____

Claim #: _____ Adjuster's name/phone: _____

Other insurance: _____

Insured's name (if other than patient) Policy #: _____

Insurance Company Name: _____

Phone#: _____

Address: _____ City: _____ State/Zip: _____

27. Have you missed time from work? ☐ yes ☐ no Work hours are: ☐ full-time ☐ part-time

If you have missed time from work, how much time have you missed? _____

28. Did the accident occur during your work hours? ☐ yes ☐ no

29. Did you seek medical help immediately/soon after the accident? ☐ yes ☐ no

If yes, how did you get there? _____

30. Doctor/hospital/clinic seen: _____ Date: _____

31. What was done? _____

Were x-rays taken? ☐ yes ☐ no If yes, of what body part? _____

32. What treatments/prescriptions were given? ☐ bed rest ☐ brace ☐ adjustments ☐ medications

33. What benefit(s) did you receive from treatment(s)? _____

_____

34. Date of last treatment: _____

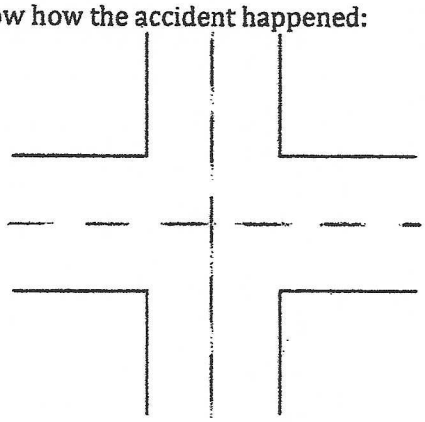
35. Are any of your activities of daily living any different now compared to before the accident?
☐ yes ☐ no

List anything you are unable to do: _____

List anything that is painful to do: _____

List anything that is difficult to do: _____

36. Indicate on the diagram below how the accident happened:



Comments: _____

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