

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 ()