

ACCIDENT/INJURY QUESTIONNAIRE

Name: (Last, First MI) _____ Today's Date: _____

■ ACCIDENT INFORMATION

Date of Injury: _____

Please Describe how the accident occurred.

■ ACCIDENT INFORMATION

Where in the car were you at the time of the accident:

Driver Side Passenger Side Front Row Rear Row Pedestrian Other: _____

Were you wearing seat belt? Yes No Did airbag deploy? Yes No

Where on your car was impacted? Front Rear Passenger side Driver Side Other _____

■ MEDICAL INFORMATION

At the time of the accident

Did you feel pain immediately after the accident? Yes No

If no, when? Later that day Next day When? _____

Did you go to a hospital or see any other doctor? Yes No *How:* Ambulance Other: _____

Did you suffer any cuts/bruises? Yes No (Describe) _____

Imaging taken? (x-ray, CT, MRI) Yes No Region(s) _____

Fractures? Yes No Region(s)/Location(s) _____

Since the accident

Are your symptoms: Getting Better Staying the same Getting worse

Have you done anything to care for the symptoms? (i.e. ice, heat, rest avoid activities etc.)? Yes No

If yes – What? _____

Are you currently working? Yes No Date last worked: _____

Did you miss any work from the accident? Yes No Dates: _____

■ HEALTH STATUS BEFORE THE ACCIDENT

Were you capable of performing all your work activities without restriction? Yes No

If no – What were the restrictions? _____

Have you ever had any complaints in the involved area before? Yes No

If yes – Were they present at the time of the incident/injury? Yes No

If yes - Summarize these complaints prior to the accident: _____

AUTO ACCIDENT LEGAL INFORMATION

Patient Name: _____

Was a police report filed? Yes No

Have you retained an attorney? Yes No

If yes - name of attorney _____ Phone _____

Your Auto Insurance Company _____

Policy # _____ Claim # _____

Name of Claims Adjuster _____ Phone _____

Do you have Med Pay on your Auto Policy? Yes No

If yes - How much? _____

Other Auto Insurance Company _____

Claim # _____

Name of Claims Adjuster _____ Phone _____