Automobile Accident Questionnaire

Please answer all questions completely

PATTIENT: _____ DATE: _____

Your Insurance Carrier: _____ Date of accident_____
Address of Carrier: _____
Policy Number: Claim Number: _____
Adjuster handling your claim:_____ Carriers Phone # : _____

Please explain in detail how your accident happened_____
_____
_____

If you were not at fault, please provide the other drivers insurance information:
Driver at Fault: _____Claim Number: _____
Their Insurance Carrier: _____ Policy Number: _____
Their Adjuster: _____ Phone Number: _____

You were heading (circle one) north south east west on _____ (street or highway)
Other vehicle was headed (circle one) north south east west on _____ (street or highway)
Were police notified? (circle one) yes no
Were you knocked unconscious? (circle one) yes no If so, for how long? _____
Were you struck from (circle one) behind front left side right side
You were (circle all that apply) driver passenger front seat back seat using a seat belt other_____

What were the time and date of present injury? _____
Where did you feel pain immediately after the accident? _____
Where were you taken after the accident? _____
What treatment was given? _____
Was any other doctor consulted after the accident? yes no If so, who? _____
What was the diagnosis? _____
What treatment was given? _____
How often did you see the doctor? _____
How long did you see the doctor? _____

Have you ever had any complaints in the involved area before? yes no If so, describe the complaint:
_____
Before the injury were you capable of working on an equal basis with others your age? yes no
Are your work activities restricted as a result of this accident? yes no
Since this injury are your symptoms (circle one) improving getting worse same?

Have you retained an attorney? yes no
If so, his/her name and address _____
Do you have Health Insurance? yes no If so, who is your insurance company?