Automobile Accident Questionnaire

In order for us to understand your condition properly, please be as neat and accurate as possible while completing this form. Thank you.

Name:_____ Sex: M F Marital Status:_____ Date of Birth:_____ Home Phone:_____

Address:_____ City:_____ State:_____ Zip:_____

Occupation:_____ How were you referred to our office? _____
(Indicate if child, student, housewife, unemployed, retired)

Social Sec #:_____ Business Phone:_____ Company Name:_____ Location:_____

Spouse First Name:_____ Spouse S.S. #:_____ Spouse Employer:_____ Location:_____

Please explain in detail how your accident happened:_____

_____

_____

_____

Insurance Co._____ Policy #:_____ Claim #:_____

Driver of other vehicle (if any)

Name:_____ Insurance Company:_____ Policy #:_____

Driver of vehicle in which you were injured (if applicable)

Name:_____ Insurance Company:_____ Policy #:_____

Name of your insurance adjustor:_____ Have you retained an attorney? Yes_____ No_____

If yes, his/her name and address:_____

You were heading North_____ South_____ East_____ West_____ on _____ (Road or Highway)

Other vehicle was heading North_____ South_____ East_____West_____ on _____ (Road or Highway)

Were police notified? Yes_____ No_____ Were you knocked unconscious? Yes_____ No_____ If yes, for how long?_____

You were struck from: Behind_____ Front_____ Left side_____ Right side_____

Please check or circle all that apply on the following question.

You were: Driver_____ Passenger_____ Front seat_____ Back seat: Left Ctr Right Using seat belts_____ Other protective devices_____

Date of Accident / Injury:_____ Time:_____

Did you feel pain immediately after the accident? Yes_____ No_____ If yes, where did you feel pain?_____

If no, when and where did you start feeling pain? _____

Where were you taken after the accident? _____

Was treatment given? Yes_____ No_____ If yes, what treatment? _____

Were any other doctors consulted after your accident? Yes_____ No_____

If yes, what was doctor's name? _____ D.C. _____ M.D. _____ D.O. _____ D.D.S. _____

What was the diagnosis? _____

Have you ever had any complaints in the involved area before? Yes_____ No_____

If yes, what were the complaints? _____

Before the accident, 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: Improving?_____ Getting worse?_____ The same? _____

Signature: _____ Date: _____
(Parent or Guardian if minor)