AUTO ACCIDENT QUESTIONNAIRE

Name: _____

Today's Date:_____

Date of Accident:_____

Where were you? □ driver □ passenger □ pedestrian
Struck from? □ behind □ right side □ left □ side □ front □ auto parked
Did your car strike the others involved? □ yes □ no
Did the other car strike yours? □ yes □ no
Accident Location City_____
Road conditions at the time of the accident? □ wet □ dry □ icy □ other
Did the police come to the accident? □ yes □ no Do you have a copy of the report? □ yes □ no
Who was given a ticket? Who was at fault?_____
Were you wearing a seat belt? □ yes □ no If so, Shoulder/Lap Belt or Lap Belt
Did you know you were going to be hit before the accident?_____
Did you lose consciousness (black out) upon impact? □ yes □ no If so, estimate how long?_____
Were you taken to the hospital? □ yes □ no If so, were you taken by ambulance ? □ yes □ no
Have you seen any other medical facilities for your injuries? □ yes □ no If so, did they take x-rays □ yes □ no
If so, Where? _____Dr._____
Were you prescribed any medications? □ yes □ no If so, what_____
Was your head facing straight forward at the time of the impact? □ yes □ no
If no, what direction was it facing and how much?_____

PLEASE CHECK SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT

□ Headache □ Dizziness □ Light Bothers Eyes □ Diarrhea
□ Neck Pain □ Head Seems Too Heavy □ Loss of Memory □ Feet Cold
□ Neck Stiff □ Pins and Needles in Arms □ Ears Ringing □ Hands Cold
□ Sleeping Problems □ Pins and Needles in Legs □ Face Flushed □ Stomach Upset
□ Back Pain □ Numbness in Fingers □ Buzzing in Ears □ Constipation
□ Nervousness □ Numbness in Toes □ Loss of Balance □ Cold Sweats
□ Tension □ Shortness of Breath □ Fainting □ Fever
□ Irritability □ Fatigue □ Loss of Smell □
□ Chest Pain □ Depression □ Loss of Taste □

CAR YOU WERE IN Who was:
Driver of the car you were in?_____ Registered Owner_____
Insurance company?_____ Phone No._____
Claims Adjuster Claim No._____
Policy No._____
Make Model Year_____
What is the estimated damages to the vehicle you were in? $_____
What parts of the vehicle were damaged_____
Was your vehicle stopped at the time of impact? □ yes □ no
If so, was the driver's foot on the brake? □ yes □ no
If no, estimate the speed of the vehicle you were in? mph_____
If the vehicle was traveling was it: Slowing, Gaining Speed, Going at steady speed

OTHER VEHICLE Who was:
Driver of the other car? Registered Owner_____
Insurance company of the other car? Phone No.
Claims Adjuster Claim No._____
Policy No._____
Make Model Year_____
What is the estimated damages to the other vehicle? $_____
What parts of the vehicle were damaged during the accident:_____
Was the other vehicle stopped at the time of impact? □ yes □ no
If no, estimate the speed of the other vehicle? Mph_____
Do you have an attorney for this case? □ yes □ no
If so, Attorney's name_____
Address Phone No._____

Patient's Signature _____Date _____