AUTOMOBILE ACCIDENT QUESTIONNAIRE

Date: _____

Name: _____
(First) (Mid Int.) (Last)

Please explain in detail how your accident happened: _____

_____

Give time and date present injury occurred: _____AM/PM Date: _____/_____/_____

Were you heading? ☐North ☐South ☐East ☐West on _____Hwy/Street

Other vehicle was heading? ☐North ☐South ☐East ☐West on _____Hwy/Street

Number of people in vehicle: _____ Were police notified? ☐Yes ☐No

Did head strike windshield or object? ☐Yes ☐No Were you knocked unconscious? ☐Yes ☐No If yes for how long? _____

Where were you struck from? ☐Front ☐Behind ☐Left Side ☐Right Side

Were you? ☐Driver ☐Passenger Front ☐Passenger Back Were you wearing your seatbelt? ☐Yes ☐No

Did you feel pain immediately after the accident? ☐Yes ☐No ☐Later that day ☐Next day ☐When _____

Where did you feel pain immediately after the accident? _____

Where were you taken after the accident? _____

What treatment was given? _____

Was any doctor consulted after the accident ☐Yes ☐No If so give doctor's name: _____

Doctor's Diagnosis: _____

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 yes, what were the complaints? _____

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 the injury, are your symptoms: ☐Improving ☐Getting Worse ☐The same

I understand that I am financially responsible for all charges whether or not paid for by insurance.

_____ _____
(Signature) (Date)