

AUTOMOBILE ACCIDENT QUESTIONNAIRE

PLEASE ANSWER ALL QUESTIONS COMPLETELY

Date _____

Patient _____ No. _____
Sex _____ Marital Status _____ Date of Birth _____ Home Phone _____
Address _____ City _____ State Zip _____
Email: _____ Occupation _____
Who referred you to our office? _____
Social Sec. # _____ Business Phone _____ Company Name _____
Company Address _____
Please explain in detail how your accident happened? _____

Driver of other vehicle (if any) _____ Date of Birth _____
Insurance Company _____ Address _____ Phone No: _____
Policy No. _____
Claim No. _____
Name of person who has made contact with you _____
Name of driver of vehicle in which you were injured (self or other) _____
Insurance Company _____ Address _____ Phone No: _____
Policy No. _____
Claim No. _____
Name of Person who has made contact with you _____
Have you retained an attorney? Yes No Not Yet
If so, his/her name, address & phone # _____
Give time and date present injury occurred _____ AM PM ____/____/____
You were heading? North South East West on _____ (street or highway)
Number of people in your vehicle _____
Were police notified? Yes No Did head strike windshield or object? Yes No
Were you knocked unconscious Yes No If so, for how long _____
You were struck from? Behind Front Left Side Right Side
You were? Driver Passenger Front seat Back seat Using seat belts Other protective devices
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? _____
Was treatment given? _____
Was any doctor consulted after the accident? Yes No
If so, give doctor's name _____ D.C., M.D., D.O., D.D.S.
Doctor's 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, 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?