Auto Accident Questionnaire

Name: _____ **Today's Date:** _____

Please explain in detail how your accident happened

_____
_____
_____

Date of Accident: _____ **Time:** _____ am pm **Location:** _____

Were you the: □ **Driver** □ **Pedestrian** □ **Front Passenger** □ **Rear Passenger** □ **Other** _____
Were you wearing your seat belt? □ **Yes** □ **No**
Was the vehicle equipped with airbags? □ **Yes** □ **No** **If yes, did they inflate?** □ **Yes** □ **No**
Make and Model of vehicle you were occupying: _____
What did your vehicle impact? □ **another vehicle/make and model:** _____
□ **other:** _____
Did any part of your body strike anything in the vehicle? □ **Yes** □ **No** **If yes, please describe:** _____
_____
In which direction were you heading? □ **N** □ **S** □ **E** □ **W**
What was the approximate speed of your vehicle? _____**m.p.h.**
Other driver, if applicable, was heading □ **N** □ **S** □ **E** □ **W**
Approximate speed of other driver: _____**m.p.h.**
Did the impact to your vehicle come from the: □ **Front** □ **Rear** □ **Right Side** □ **Left Side** □ **Other:** _____
During impact, were you facing: □ **Right** □ **Left** □ **Forward**

Describe how you felt immediately after the accident: _____
_____
_____

Were you knocked unconscious? □ **No** □ **Yes** **If yes, how long?** _____
Did you go to a hospital/emergency center? □ **No** □ **Yes** **If yes, where and when?** _____
_____
Describe any treatment you received: _____
Were x-rays taken? □ **Yes** □ **No** **Was medication prescribed?** □ **Yes, type :**_____ □ **No**
Have you seen any other doctor for this accident? □ **Yes, Dr's Name:** _____ □ **No**
Treatment: _____ **Recommendations:** _____

Check symptoms you have noticed since the accident:

□ **Headache**	□ **Dizziness**	□ **Nausea**	□ **Tingling in Arms**
□ **Memory Loss**	□ **Loss of Balance**	□ **Fever**	□ **Numbness in Fingers**
□ **Blurred Vision**	□ **Light Bothers Eyes**	□ **Hands Cold**	□ **Upper Back Pain**
□ **Buzzing in Ears**	□ **Head Seems Too Heavy**	□ **Feet Cold**	□ **Upper Back Stiffness**
□ **Ears Ringing**	□ **Loss of Smell**	□ **Jaw Problems**	□ **Low Back Pain**
□ **Fainting**	□ **Loss of Taste**	□ **Neck Pain**	□ **Leg Pain**
□ **Face Flushed**	□ **Shortness of Breath**	□ **Neck Stiffness**	□ **Tingling in Legs**
□ **Nervousness**	□ **Chest Pain**	□ **Arm/Shoulder Pain**	□ **Numbness in Toes**

Have you ever had any complaints in the involved area(s) before? □ **Yes** □ **No**

Are your work/school activities restricted as a result of this accident? □ **Yes** □ **No**

Since this injury are your symptoms: □ **improving** □ **getting worse** □ **constant** □ **same** □ **comes and goes**

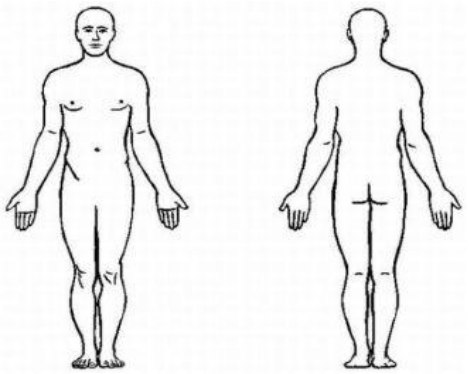
List major complaints and rate the intensity of the pain on a scale of 1 to 10.

1. Primary complaint: _____ 1 2 3 4 5 6 7 8 9 10

2. Secondary complaint: _____ 1 2 3 4 5 6 7 8 9 10

3. Other complaint: _____ 1 2 3 4 5 6 7 8 9 10

Please mark on the drawings below the area(s) and type of pain/sensation that you are feeling.



Numbness…….N
Pain……P
Tingling……..T
Ache……A
Stiffness……..S

Insurance Companies Involved

Your Auto Insurance Company: _____
Address: _____
Telephone Number: _____Claim #: _____
Name of Adjustor: _____

Other Party's Insurance Company: _____
Address: _____
Telephone Number: _____Claim#: _____
Name of Adjustor: _____

Do you have an attorney that has advised you in this case: ☐ Yes ☐ No
If yes, attorney's name: _____
Address: _____
Telephone Number: _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

_____

Signature **Date**