AUTOMOBILE ACCIDENT QUESTIONNAIRE

Please answer all questions completely.

DEAR PATIENT: This information is considered confidential. Please be as neat and accurate as possible. Thank you.

NAME:____ DATE:___________________ PATIENT #:_____________

PATIENT'S AUTO INSURANCE CO.: ____
POLICY #: ______________________________________ CLAIM #: ____________________________________
NAME OF YOUR INSURANCE ADJUSTER:____
PHONE #: ____ FAX #: ______________________________________

MEDICAL PAY VERIFICATION

Your car insurance company will only release this information to you, the policy holder.
Please call your car insurance provider to obtain this information.
Using your medical pay will not raise your car insurance rates

Do you have medical pay? YES NO
If so, how much? $1,000 $2,000 $5,000 $10,000
Is your medical pay primary or secondary?________________________________
Do you have uninsured motorist's policy on your insurance? YES NO
If so, what is the limit?______________________________

NAME OF DRIVER OF OTHER VEHICLE : ___________________________________ PHONE #: _______________
OTHER DRIVER INSURANCE CO.:____ PHONE #: _______________
INSURANCE ADJUSTER: ____
POLICY #: ____ CLAIM #: _____________________________________

Name of driver of vehicle if you were a passenger:____
Other drivers insurance company: ________________ Policy #: ___________________ Phone #: _________________
Insurance adjuster: _______________________________________ Claim #: __________________________________

HAVE YOU RETAINED AN ATTORNEY? ( ) YES ( ) NO
ATTORNEY NAME: ____ PHONE #: ________________

DATE OF ACCIDENT: __________________ TIME OF ACCIDENT __________ CITY & STATE _______________

You were heading: North (___) South (___) East (___) West (___)

On (street or highway)
____
Other vehicle was heading: North (___) South (___) East (___) West (___)
On (street or highway)
____
Road conditions at the time of accident: Wet (___) Dry (___) Icy (___) Other (___)
Were there any witnesses? Yes (___) No (____)
Did the police come to the accident scene? Yes (___) No (___)
Were you taken to the hospital? Yes (___) No (___)
If yes, what hospital? ____________________________________ How did you get to hospital? ______________
What parts of your body were x-rayed at the hospital?
____
What treatment was given?
____
What was the diagnosis?
____
Was another doctor consulted after your accident? Yes (___) No (___) Doctor's name:___________________
What treatment was given?
____
What was diagnosis?
____

THE FOLLOWING QUESTIONS PERTAIN TO YOU, THE PATIENT AND THE VEHICLE YOU WERE IN:

How much damage to the vehicle you were in $ __________________
Where were you seated in the vehicle?
____
Were you aware of the approaching collision prior to impact, or did the impact catch you by surprise? _____________
Did you lose consciousness (black out) upon impact? Yes (___) No (___)
If you did lose consciousness, estimate for how long___________________
Where was the headrest at the time of the accident: Bottom of neck / Bottom of head / Middle of head
Were you: Driver / Passenger / Back sat Driver Side / Back Seat Passenger Side
You were struck from: Behind / Front / Driver side / Passenger Side
Number of people in your car ____________________________________
Were you wearing a seatbelt? Yes (___) No (___)
If "yes" was it a lap seatbelt or a shoulder-lap seatbelt?
____
List the year, make, and model of the vehicle you were in: Year______; make ______________; model ___________
Was your car stopped at the time of impact? Yes (___) No (___)
If "yes" was the driver's foot also on the brake? Yes (___) No (___)
If "no" please estimate the speed of the vehicle you were in ___________ m.p.h.
Please describe how you felt:

During the accident
____

Immediately after the accident:
____

Later that day: ____

The next day: ____

Since the accident, your symptoms are: Improving / Getting Worse / Same

Have you noticed any activity restrictions as a result of this accident? Yes (_____) No (_____)

If yes, please explain ____

CONTINUED: QUESTIONS PERTAINING TO THE PATIENT AND THE VEHICLE:

If the vehicle was moving at the time of impact, was it:

Slowing down?	Yes (___)	No (___)
Gaining speed?	Yes (___)	No (___)
Traveling at a steady rate of speed?	Yes (___)	No (___)

Please describe in detail, to the best of your knowledge, what happened during this accident:

____

What bleeding cuts did you get during this accident? ____

What bruises did you get during this accident? ____

On what part of the auto did the following body parts hit:

- Head hit ____
- Chest hit ____
- Right/left shoulder hit ____
- Right/left arm hit ____
- Right/left hip hit ____

- Right/left leg hit
  ____

- Right/left knee hit
  ____

- Other
  ____

What of the following car parts broke during the accident:

- Windshield (___) Front seat back (___) Right/left side window (___) Steering wheel (___)
- Other:
  ____

Was the trunk of your body pointed straight forward at the time of collision? Yes (___) No (___)
If "no", which direction was it turned and by how much?
____

Do you have any previous illnesses which relate to this case ( ) Yes ( ) No If yes, please describe:
____

Have you lost time from work as a result of this accident? ( ) Yes ( ) No If yes, please complete the following:
Last day worked:
____
Type of employment:
____
Present Salary:
____
Are you being compensated for time lost from work? ( ) Yes ( ) No
If yes, please state type of compensation you are receiving:
____

THE FOLLOWING QUESTIONS PERTAIN TO THE OTHER VEHICLE INVOLVED IN THE ACCIDENT:

What is the year, make, and model of the other vehicle?
Year ________ Make _________________________ Model ___________________________

Was the other vehicle moving at the time of the collision? Yes (___) No (___)
If "yes", what was its approximate speed? _________ m.p.h.
If the other vehicle was moving at the time of collision, was it:

- Slowing down? Yes (___) No (___)
- Gaining speed? Yes (___) No (___)
- Traveling at a steady rate of speed? Yes (___) No (___)