

## AUTOMOBILE ACCIDENT QUESTIONNAIRE

1. Name \_\_\_\_\_ Today's date \_\_\_\_\_
2. Date of accident \_\_\_\_\_ Time of accident \_\_\_\_\_ AM/PM
3. Address of accident \_\_\_\_\_  
City & State of accident \_\_\_\_\_
4. What direction were you heading? \_\_\_\_\_ Other vehicle was headed? \_\_\_\_\_
5. Did police come to the accident scene? \_\_\_\_\_ Were you taken to a hospital? \_\_\_\_\_  
If so, how were you transported? \_\_\_\_\_  
Name and address of the hospital? \_\_\_\_\_  
Were you x-rayed at the hospital? \_\_\_\_\_
6. Was any other doctor consulted after the accident? \_\_\_\_\_ Doctor's name? \_\_\_\_\_  
What was the diagnosis? \_\_\_\_\_ Any treatment given? \_\_\_\_\_  
What type of treatment? \_\_\_\_\_ How many treatments? \_\_\_\_\_
7. Please list any other health care providers consulted for this accident. \_\_\_\_\_  
\_\_\_\_\_
8. Where did you feel pain after the accident? \_\_\_\_\_  
When did you first start to feel this pain? \_\_\_\_\_
9. Have you ever had complaints in the involved area before? \_\_\_\_\_  
If so, what were the complaints? \_\_\_\_\_
10. Since this injury, are your symptoms : Improving? \_\_\_\_\_ Getting worse? \_\_\_\_\_ Same \_\_\_\_\_
11. Are your work activities restricted as a result of this accident? \_\_\_\_\_  
What type of activities are required in your normal work day? \_\_\_\_\_  
\_\_\_\_\_

The following questions pertain to you, the patient, and the vehicle you were in.

1. List the year, make, and model of the vehicle you were in: Year \_\_\_\_\_ Make \_\_\_\_\_  
Model \_\_\_\_\_
2. Was your car stopped at the time of impact? \_\_\_\_\_ If no, what is the estimated speed of the car you were in? \_\_\_\_\_ mph
3. If the car was moving at the time of impact, was it slowing down \_\_\_\_ ; or was it gaining speed? \_\_\_\_ ; Were there any skid marks? \_\_\_\_\_
4. Did your car subsequently hit another car? \_\_\_\_\_ or another object? \_\_\_\_\_
5. Was your car pushed ahead or in any other direction as a result of impact? \_\_\_\_\_
6. Where were you seated in the car? Driver \_\_\_\_\_ passenger \_\_\_\_\_ front seat \_\_\_\_\_  
back seat \_\_\_\_\_
7. Were you wearing a seatbelt? \_\_\_\_\_ If yes, was it a shoulder-lap belt \_\_\_\_\_ or lap only \_\_\_\_\_
8. Were you aware of the approaching collision prior to the impact \_\_\_\_\_ or did the impact take you by surprise? \_\_\_\_\_
9. Was the trunk of your body pointed straight forward at the time of impact? \_\_\_\_\_ If no, which direction was it turned and by how much? \_\_\_\_\_
10. Was your head pointed straight forward? \_\_\_\_\_ If no, what direction was it turned and by how much? \_\_\_\_\_
11. How far is the top of the headrest or seat back from the top of your head? (approximately) \_\_\_\_\_ inches above \_\_\_\_\_ below \_\_\_\_\_
12. Did you lose consciousness (blackout) upon impact? \_\_\_\_\_ If yes, approximately how long? \_\_\_\_\_

13. Please describe, to the best of your knowledge, what happened during this accident:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

14. What is the damage estimate to the car you were in? \_\_\_\_\_ Do you have photos? \_\_\_\_\_  
13

15. Which of the following car parts broke in this accident?

Windshield \_\_\_\_\_ Front seat back \_\_\_\_\_  
Rt / Lt side window \_\_\_\_\_ Airbag deployment? Y/N \_\_\_\_\_  
Steering wheel \_\_\_\_\_ Other \_\_\_\_\_

16. What bleeding cuts did you get during this accident? \_\_\_\_\_

What bruises did you get during this accident? \_\_\_\_\_

17. On what part of the auto did the following body parts hit?

Head hit \_\_\_\_\_ Rt / Lt hip hit \_\_\_\_\_  
Chest hit \_\_\_\_\_ Rt / Lt leg hit \_\_\_\_\_  
Rt / Lt shoulder hit \_\_\_\_\_ Rt / Lt knee hit \_\_\_\_\_  
Rt / Lt arm hit \_\_\_\_\_ Other \_\_\_\_\_

\*\*\*\*\*

The following questions pertain to the other vehicle involved in the accident:

1. What is the year, make, and model of the other vehicle? Year \_\_\_\_\_  
Make \_\_\_\_\_ Model \_\_\_\_\_ Describe damage to the other  
vehicle \_\_\_\_\_ Any other cars involved? \_\_\_\_\_
2. Was the other car moving at the time of impact? \_\_\_\_\_ If yes, what was the  
approximate speed? \_\_\_\_\_ mph
3. If the other car was moving at the time of the collision, was it slowing down? \_\_\_\_\_  
gaining speed? \_\_\_\_\_ Any skid marks? \_\_\_\_\_

1. Who is your insurance company? (please include address and phone #) \_\_\_\_\_  
\_\_\_\_\_
2. Did you file a claim? \_\_\_\_\_ Claim #: \_\_\_\_\_
3. Adjustor's name \_\_\_\_\_ Telephone # \_\_\_\_\_
4. Driver of car in which you were in? (if applicable) \_\_\_\_\_ Insurance  
company? \_\_\_\_\_ policy # \_\_\_\_\_
5. Does the driver have a Medical Pay (Med Pay) policy? \_\_\_ Amount of policy? \_\_\_\_\_  
Approximate amount left on Med Pay? \_\_\_\_\_
6. What are the UM/UIM policy limits? \_\_\_\_\_
7. Driver of the other car? (if applicable) \_\_\_\_\_  
Insurance company? \_\_\_\_\_ policy # \_\_\_\_\_  
Claims adjustor \_\_\_\_\_ Telephone #: \_\_\_\_\_
8. Who received the citation for the accident? \_\_\_\_\_ For what? \_\_\_\_\_
9. Have you retained an attorney? \_\_\_\_\_ If yes, attorney's name and address \_\_\_\_\_  
\_\_\_\_\_
10. Do you have health insurance? \_\_\_\_\_ Company? \_\_\_\_\_

\*\*\*\*\*

If you have been in previous auto accidents, please list the year each was in:

1. \_\_\_\_\_ Injuries sustained? \_\_\_\_\_ Claims made? \_\_\_ Treatment? \_\_\_\_\_
2. \_\_\_\_\_ Injuries sustained? \_\_\_\_\_ Claims made? \_\_\_ Treatment? \_\_\_\_\_

\_\_\_\_\_  
Name printed

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date