AUTO ACCIDENT QUESTIONAIRE

Name: ______________________________ DOB: __________ Phone: ______________

Address: _____________________ City: _______________ State: _____ Zip: _________

Your Automobile Insurance Information:

Your Ins. Co: _________________________ Policy# ___________________________

Have you filed a claim with YOUR policy? ☐Yes ☐ No Claim #:_________________________

Adjuster Name: _________________________ Adjuster Phone:______________________

At-Fault Party's Automobile Insurance Information:

Responsible Party's Name: __________________ Claim #:___________________________

Address: _____________________ City: _______________ State: _____ Zip: _________

Policy Holders Name: ____________________ Policy# ___________________________

Adjuster Name: _________________________ Adjuster Phone: ______________________

Attorney: Do you have an attorney? ☐ Yes ☐ No

Name: ___________________ Phone: _____________ Fax/Email:___________________

Address: ____________________ City: ________________ State: _____ Zip: _________

NATURE OF ACCIDENT

1. Date of Accident: ________________ Time of Accident: _______________
2. Were you: ☐ Driver ☐Passenger ☐ Front Seat ☐ Backseat

   Does your car have headrests? ☐Yes ☐No

   If yes, what height was it at the time of impact? ☐Bottom of Neck ☐ Bottom of Head ☐Middle of Neck
3. Number of People in Vehicle _______ Were you wearing seat belts? ___________________
4. What direction were you headed? ☐North ☐South ☐East ☐West
5. What direction was the other vehicle headed? ☐North ☐South ☐East ☐West
6. Were you struck from: ☐Behind ☐Front ☐Left Side ☐Right Side
7. Approximate speed of your car? _________mph Other Car ________mph
8. Were you knocked unconscious? ☐Yes ☐No If yes, how long? _______________
9. Were police notified? ☐Yes ☐No
10. In your own words, please describe the accident: _______________________________________

    ____

    ____

11. Did you have any physical complaints before the accident: ☐Yes ☐No If yes, please describe:

    ____

    ____

12. Please describe how you felt:
   a. DURING the accident: ____________________
   b. IMMEDIATELY AFTER the accident: ____________________
   c. LATER THAT DAY: ____________________
   d. THENEXT DAY: ____________________

13. What are your PRESENT complaints and symptoms? ____________________

____

____

14. Do you have any congenital (from birth) factors which relate to this problem? ☐Yes ☐No
If YES, please describe: ____________________

15. Do you have any previous illnesses which relate to this case? ☐Yes ☐No
If yes, please describe:____________________

16. Have you ever been involved in an accident before? ☐Yes ☐No If yes, please describe, including dates and types of accidents, as well as injury(ies) received: ____________________

____

17. Where were you taken after the accident? ____________________

18. Have you been treated by another doctor since the accident? ☐Yes ☐No If yes, please list doctor's name and address: ____________________
What type of treatment did you receive? ____________________

19. Since this injury occurred, are your symptoms ☐Improving ☐Getting Worse ☐Unchanged

20. **CHECK SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT:**

☐ Headaches	☐ Irritability	☐ Numbness in toes	☐ Face Flushed	☐ Feet Cold
☐ Neck Pain	☐ Chest Pain	☐ Shortness of Breath	☐ Buzzing in ears	☐ Hands Cold
☐ Neck Stiff	☐ Dizziness	☐ Loss of Balance	☐ Stomach Upset	☐ Fatigue
☐ Depression	☐ Fainting	☐ Hands Seem too Heavy	☐ Sleep Problems	☐ Constipation
☐ Back Pain	☐ Loss of Smell	☐ Pins/Needles in Arms	☐ Light bothers eyes	☐ Cold Sweats
☐ Nervousness	☐ Loss of Taste	☐ Pins/Needles in Legs	☐ Loss of Memory	☐ Fever
☐ Tension	☐ Ears Ringing	☐ Numbness in Fingers	☐ Diarrhea	☐ Other

Symptoms other than above____________________

21. Have you lost time from work as a result of this accident? ☐Yes ☐No (If yes please complete this question.)
   a. Last Day Worked: ____________________
   b. Type of Employment: ____________________
   c. Present Salary: ____________________
   d. Are you being compensated for time lost from your work? ? ☐Yes ☐No If yes, please state type of compensation you are receiving: ____________________

22. Do you notice any activity restrictions as a result of this injury? ☐Yes ☐No If yes, please describe: ____________________

____

23. Other pertinent information: ____________________

Print Name: ____________________ **Sign & Date:**____________________