Automobile Accident Questionnaire

Name:_____ Date of Injury:_____

Patient's Auto Insurance Co:_____

Insurance Adjuster:_____ Claim #:_____

Phone #:_____Fax #:_____

Have you retained an Attorney? □Yes □ No

Attorney Name:_____ Phone #:_____

Road conditions: □Wet □Dry □Icy □Other_____ Did the police come to the scene? □Yes □ No

Were you taken to the hospital? □Yes □ No If yes, what hospital?_____

Were you x-rayed at the hospital?_____

Did you consult another doctor for this accident? □Yes □ No Doctor's Name:_____

What was the diagnosis?_____ What treatment was given?_____

What type of car were you in? Year_____ Make_____Model_____

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 (blackout) upon impact? □Yes □ No

Were you wearing a seatbelt? □Yes □ No If yes, which type: □ Lap seatbelt □ Shoulder/lap seatbelt

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, then estimate the speed of the vehicle you were in:_____ mph

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

_____

_____

_____

How did you feel: 1. Before the accident:_____

2. Immediately after the accident:_____

3. Later that day:_____

4. The next day:_____

_____ _____

Signature of Patient/Guardian Date