AUTOMOBILE ACCIDENT QUESTIONNAIRE

Name: ____ Today's Date: ___/___/___

ACCIDENT DETAILS:

Date of Accident: ___/___/___ Time of Day: ____________ AM PM Location of Accident: ______________

Were you a ☐ Driver ☐ Passenger ☐ Pedestrian Name of Driver (if not you): ______________________

Was anyone else in the vehicle with you? ☐ YES ☐ NO If yes, who?______________________________

Speed of your vehicle:_________m.p.h. Speed of other vehicle:_________m.p.h.

Make and Model of your vehicle ____

Dollar amount of damage done to vehicle $_________ ☐Mild ☐Moderate ☐Extensive ☐ Totaled ☐Unsure

Visibility ☐ Poor ☐ Fair ☐ Good Weather: ☐Snowing ☐Raining ☐Windy ☐Foggy ☐Clear

Were you struck from ☐ Behind ☐ Right Side ☐ Left Side ☐ Front

Were you wearing a seat belt? ☐ YES ☐ NO Were you wearing the shoulder harness? ☐ YES ☐ NO

Does the vehicle have an airbag? ☐ YES ☐ NO Air bags deploye? ☐ Yes ☐ No

Did your body strike anything in the car? ☐ YES ☐ NO Describe in detail: ______________________

Did you see the accident coming? ☐ Yes ☐ No Were you braced for impact ☐ Yes ☐ No

Head Rest Position: ☐ Even with top of head ☐ Even with bottom of head ☐ Middle of neck Were you dazed? ☐ Yes ☐ No

Were you rendered unconscious as a result of the collision? ☐ YES ☐ NO How long?____________________

Were you looking straight ahead, to the left, or to the right? ☐ Straight Ahead ☐ To the Left ☐ To the Right

Was your head injured? ? ☐ Yes ☐ No Other parts injured_________________________________

Immediately after the accident did you experience ☐ Headaches ☐ Neck Pain ☐ Low back pain Other:___________

Were you taken to the hospital after the accident? ☐ YES ☐ NO By ambulance or private car? ____________

Were you taken to the hospital *immediately* after the accident? ☐ YES ☐ NO

If not, how much time had elapsed before you went to the hospital? ______________________________

Which hospital were you taken to? ____

Tests done at Hospital: ☐X-Rays ☐MRI ☐CT Scan ☐ Lab Work ☐other:______________________________

Have you seen any other Doctor for this accident ☐ Yes ☐ No

Name of Doctor	Tests/Procedures done

Have you ever been in a previous auto accident? Describe all instances, giving approximate dates of the accidents, as well as the injuries sustained, and names of attorneys who represented you.

Date of Accident: ___/___/___ Injuries sustained: ______________________________________

Name of Attorney in That Case: ______________________ Were you a Medicare Patient at the Time? ☐ YES ☐ NO

Approximate Year / Date When Case Settled or Was Resolved: ____________

Other: ____

Describe in detail how the accident occurred: ____

____

INFORMATION FOR OTHER VEHICLE

Make and Model of vehicle ____

Accelerating ☐ YES ☐ NO

Vehicles point of impact ☐ Behind ☐ Right Side ☐ Left Side ☐ Front

Dollar amount of damage done to vehicle $__________☐ Totaled ☐Unsure

What was the vehicle doing immediately prior to impact? ☐ Stopped ☐ Slowing Down ☐ Accelerating ☐ Other:_________
OTHER AUTO INFORMATION:

Did a police officer write up a police report on the accident? ☐ YES ☐ NO

Do you have a copy of the police report? ☐ YES ☐ NO *(if yes, please provide our office with a copy of this report)*

Was a ticket or citation issued by a police officer as a result of the accident? ☐ YES ☐ NO
Who received the ticket or citation? ____

Do you have any information, including insurance information, concerning the other parties involved in the accident? ☐ YES ☐ NO

(If yes, please provide our office with a copy of this information)

Did the accident involve a *hit-and-run* driver? ☐ YES ☐ NO

Are you, yourself, licensed to drive? ☐ YES ☐ NO *(please provide our office with a copy of your license)*

Was the car in which you were at the time of the accident registered? ☐ YES ☐ NO *(please provide a copy of the registration)*
Other: ____
Were you in your own vehicle or someone else's at the time of the accident? Check one.

☐ My own vehicle ☐ my spouse's ☐ my parent's ☐ a friend's ☐ other
If you were in someone else's vehicle, answer the following:
Name of Owner: ____
Address of Owner: ____
Do you reside with a family member who owns their own vehicle or is insured under some other auto policy? – Automobile insurance laws in applicable states require this info (check all that apply)

☐ Spouse ☐ Father ☐ Mother ☐ Guardian / Foster Parent ☐ Grandparent ☐ Sister / Brother ☐ Child ☐ None
Your Auto Insurance Company (at the time of accident): ________________________ Phone or City: ______________
Agent: ____ Phone or City: ______________

Was there any property damage to either of the vehicles as a result of the accident?

☐ both vehicles ☐ the other person's vehicle ☐ the vehicle I was in ☐ Neither vehicle was damaged

Have you been contacted by an adjuster from the other party's insurance company regarding this claim? ☐ YES ☐ NO
Adjuster: ____________________ Company: ____________________ Phone: ______________

Check all that apply: ☐ I have settled my personal injury claim with this company ☐ I have settled the property damage claim

☐ I have signed an agreement which will pay my medical expenses for a period of time (explain):

____

☐ I have not signed any agreement, nor settled any portion of my claim.

Are you currently represented by an attorney? ☐ YES ☐ NO If NO, do you wish to retain an attorney ☐ YES ☐ NO
Name of Attorney: ______________________________ Phone or City: ____________________