Automobile Accident Questionaire

PATIENT INFORMATION

Patient Name _____ DOB __/__/__ Today's Date ____/____/____

Address _____

City _____ State _____ Zip _____

Phone ( ) _____ Referred By _____

MEDICAL INSURANCE INFORMATION

Company _____

Address _____

City _____ State _____ Zip _____

Phone ( ) _____

Name of Insured _____ Relationship _____

ID No _____ Group No _____

YOUR AUTOMOBILE INSURANCE INFORMATION

Company _____ Adjuster Name _____

Address _____

City _____ State _____ Zip _____

Phone ( ) _____ Claim Number _____

Policy Holder _____ Policy Number _____

RESPONSIBLE PARTY AUTOMOBILE INSURANCE INFORMATION

Company _____ Adjuster Name _____

Address _____

City _____ State _____ Zip _____

Phone ( ) _____ Claim Number _____

Policy Holder _____ Policy Number _____

ATTORNEY INFORMATION

Name _____

Company _____

Address _____

City _____ State _____ Zip _____

Phone ( ) _____

ANY OTHER PHYSICIAN SEEN (with regards to this accident)

Name _____

Address _____

City _____ State _____ Zip _____

Phone ( ) _____ Type/Specialty _____

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ACCIDENT INFORMATION

Date of Accident ____/____/____ **Time of Accident** _____ am / pm

Patient Vehicle (year, make, model) _____

Other Vehicle (year, make, model) _____

(Please circle your choices below)

Visibility Poor / Fair / Good **Road Condition** Dry / Wet / Icy / Sandy

Was it Dark? Y / N **Were you the Driver?** Y / N

Where were you seated in the vehicle?

What was your vehicle doing at the time of accident?

Stopped at light	Stopped in traffic	Slowing down	Stopped at intersection
Proceeding straight ahead	Making a left turn	Parking	Merging onto freeway
Accelerating	Making a right turn	Exiting freeway	

Your vehicle's speed _____ **Other vehicle's speed** _____

Damage to your vehicle? Mild / Moderate / Totalled

Did your vehicle hit the other vehicle? Y / N **Did the other vehicle hit your vehicle?** Y / N

Other objects your vehicle hit _____

Did the police arrive at the scene? Y / N **Accident report filed?** Y / N

Any Tickets or Infractions issued? Y / N **To whom were they issued?** You / Your Driver / Other Party

Did you see the impact coming? Y / N **Did you brace for impact?** Y / N

Did you have your seatbelt on? Y / N **Type of belt:** Lap / Shoulder

Did your seat have a headrest? Y / N

What was the direction of your head at time of impact? (Circle all that apply)

Forward Right Left Up Down Backwards

Which airbags deployed? Driver / Passenger / Side / None

Points of Impact: What did your body hit? (Circle all that apply and indicate which body part)

Windshield	_____	Door R / L	_____
Dashboard		Window R / L	
Steering Wheel	_____	Roof	_____

Symptoms After Accident (Circle all that apply)

Headache	**Cold Sweats**	**Neck Stiffness / Pain**	**Sleeping Problems**
Ringing in Ears	**Nausea**	**Arm / Shoulder Pain**	**Depression/Anxiety**
Confusion / Memory Loss	**Numbness**	**Upper Back Pain**	**Cold Hands/Feet**
Bruising	**Fatique**	**Midback Pain**	**Constipation/Diarrhea**
Dizziness	**Nervousness**	**Lower Back Pain**	**Shooting/Radiating Pain**
Blurred / Double Vision	**Chest / Rib Pain**	**Knee / Leg Pain**	**Tension**
Difficulty Focusing	**Shortness of Breath**	**Jaw Pain**	**Other:**

Please explain: _____

_____

Automobile Accident Questionaire

OnSite Treatment

Did you receive treatment at the accident site? Y / N

If so, what treatment was provided?

Hospital Details

Trip to Hospital / ER? Y / N **If so, were you admitted?** Y / N

Hospital Transportation Type Ambulance / Drove Self / Other Private / Taxi

Name of Hospital _____ **Attending Physician** _____

Treatment Provided *(circle all that apply)*

Stitches	Pain Medication	Cervical Collar	Bandage
Ice Pack	Cast / Brace	Other (specify)	_____

Other Instructions given by the Hospital _____

_____

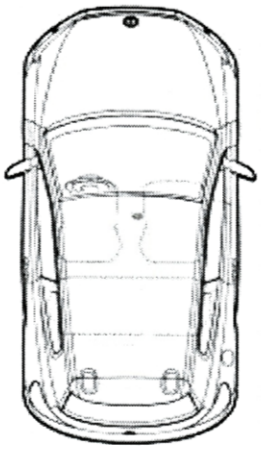
X-Rays? Y / N **What was imaged?**

Accident Details

Vehicle Diagram

(Please label point of impact on your vehicle)

front

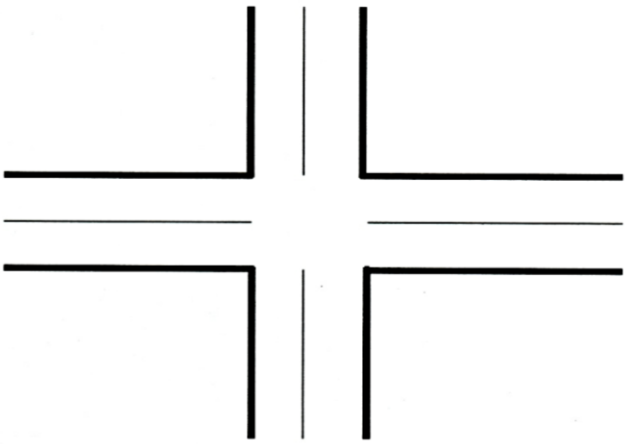


rear

Est. Amt of Damage $ _____

Intersection Diagram

(Please diagram accident and direction of travel)



Accident Description

(Please provide as much detail as possible. Use other side if needed)

_____

_____

_____

_____

_____

Patient Signature: _____ **Date:** _____