

AUTOMOBILE ACCIDENT QUESTIONNAIRE

Please answer all questions completely.

Date _____

Patient _____ Patient No. _____

Sex _____ Marital Status _____ DOB _____ Home Phone _____

Address _____ City _____ State _____ Zip _____

Occupation _____

Who referred you to our office? _____

Social Sec. No. _____ Business Phone _____

Company Name _____

Company Address _____

Please explain in detail how your accident happened

Driver of other vehicle, if any _____

Insurance Co. _____ Address _____ Phone _____

Policy No. _____ Claim No. _____

Name of person who has made contact with you _____

Have you retained an attorney? Yes No Not Yet

If so, attorney's name, address and phone _____

Time and date present injury occurred _____ : _____ AM PM on _____ / _____ / _____ (mm/dd/yy)

You were heading? North South East West on _____ (street/highway)

Number of people in your vehicle? _____

Were police notified? Yes No Did head strike windshield or object? Yes No

Were you knocked unconscious? Yes No _____

You were struck from? Behind Front Left Side Right Side

You were? Driver Passenger Front Seat Back Seat Using Seat Belts Other protective devices

Did you feel pain immediately after the accident? Yes No Later that day Next day When? _____

Where did you feel pain immediately after the accident? _____

Where were you taken after the accident? _____

Was treatment given? _____

Was any Doctor consulted after the accident? Yes No

If so, give Doctor's name _____ D.C. M.D. D.O. D.D.S.

Doctor's Diagnosis _____

What treatment was given? _____

How often did you see the doctor? _____

How long did you see the doctor? _____

Have you ever had any complaints in the involved area before? Yes No

If so, what were the complaints? _____

Before the injury, were you capable of working on an equal basis with others your age? Yes No

Are your work activities restricted as a result of this accident? Yes No

Since the injury, are your symptoms Improving? Getting Worse? The Same?