

AUTO ACCIDENT QUESTIONNAIRE

Name _____
 First Middle Initial Last

Attorney Information (if applicable)

Attorney Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Insurance Company

Primary Insurance Carrier: _____ Claim #: _____

Address: _____ City: _____ State: _____ Zip: _____

Insurance Company Phone Number: _____

Context

What is the cause of your complaint? ___Auto Injury ___Work Injury

Date of Accident/Injury: _____ Time of Injury: _____ Date of 1st Treatment: _____

Please describe how THIS ONSET of your primary complaint started (give specific details):

1. What was your position in the vehicle? ___ Driver ___ Front Passenger ___ Rear Passenger ___ Pedestrian

2. What type of vehicle were you driving? ___ Compact Car ___ Mid Size Car ___ Full Size Car ___ Compact Truck ___ Full Truck ___ Minivan ___ Full Size Van ___ Small Sport Utility ___ Large Sport Utility ___ Motorcycle ___ Motor Home ___ Bicycle

3. What was your vehicle doing just prior to the accident? ___ Stopped at a stop sign ___ Slowed down to a stop ___ At a complete stop ___ Increasing speed ___ Merging into traffic ___ Changing lanes

4. What time of day was it at the time of the accident? ___ Dawn ___ Dusk ___ Daytime ___ Night time

5. What type of road conditions did you have? ___ Snow ___ Rain ___ Ice ___ Dry ___ Other: _____

6. Who hit who? ___ You were struck by another car ___ You struck another vehicle ___ You struck a stationary object

7. What type of vehicle was the other person driving? ___ Compact Car ___ Mid Size Car ___ Full Size Car ___ Compact Truck ___ Motor Home ___ Minivan ___ Full Size Van ___ Small Sport Utility ___ Large Sport Utility ___ Motorcycle ___ Full Truck ___ Bicycle

