AUTO ACCIDENT QUESTIONAIRRE

Name_____ Date_____

A. ACCIDENT DETAILS

Date of Accident_____

Describe (in detail) what happened

_____

_____

_____

_____

_____

What city did the accident occur in?_____

Nearest crossroads of accident?_____

How many vehicles were involved? _____

What type of vehicle were you in?_____

What type of vehicle struck you?_____

How fast was your vehicle traveling? _____

How fast was the other vehicle traveling? _____

What was your vehicle doing at the time of impact?

☐ Stopped ☐ Slowing down ☐ Cruising ☐ Accelerating

☐ Turning ☐ Changing lanes ☐ Other_____

What was the other vehicle doing at the time of impact?

☐ Stopped ☐ Slowing down ☐ Cruising ☐ Accelerating

☐ Turning ☐ Changing lanes ☐ Other_____

How much damage did your vehicle sustain?

☐ Minimal ☐ Moderate ☐ Extensive ☐ Totaled

Were you aware of the impending collision? _____

Did you brace yourself for impact?_____

Where were you sitting? _____

What was your body position at impact?_____

Were you wearing a seatbelt?_____

Were you wearing a shoulder restraint?_____

Did you have a headrest behind your head? _____

What direction was your body thrown?_____

Did any part of your body strike any part of the vehicle? _____

If yes, describe_____

Were you struck by any loose objects?_____

Describe any cuts, bruising and/or abrasions you received?

_____

Did you lose consciousness? _____

Did you receive any emergency care from EMT/paramedics?_____

If so, describe _____

Were police called? _____

Who was issued a citation? _____

Did you go to a hospital/urgent care following the accident?_____

If not, why? (then skip to section C)_____

B. HOSPITAL

What hospital were you taken to?_____

How were you taken to the hospital? ☐ Ambulance ☐ AirEvac

☐ Drove myself ☐ Taken by family member/friend

When did you go to the hospital? _____

Were you admitted or released that day?_____

Did you receive any x-rays at the hospital? _____

If yes, over what region(s)?_____

Did you receive any CT scans at the hospital? _____

If yes, over what region(s)?_____

Did you receive an MRI at the hospital? _____

If yes, over what region(s)?_____

Was any blood work done at the hospital? _____

List any other tests that were done_____

Did you receive any bracing or cervical collar?_____

List any medications given at the hospital _____

_____

List any prescriptions given to you when discharged_____

_____

What diagnosis was given?_____

What instructions were you given upon discharge?

_____

C. SYMPTOMS

List any symptoms that you have experienced since the accident

_____

_____

How soon after the accident did your symptoms appear? _____

_____

Have you experienced any of the following symptoms?

☐ Nausea Vomiting	☐ Dizziness	☐ Headaches
☐ Ringing	☐ Blurred vision	☐ Numbness Anxiety
☐ Insomnia	☐ Memory trouble	☐ Other_____

List any other treatment you have received for this accident?

_____

List any of your current symptoms that were present prior to the car accident _____

D. INSURANCE

Do you have medpay on your insurance policy? _____

If so, who is your insurance carrier?_____

Adjuster_____Phone_____Policy/Claim#_____

Who is the insurance carrier for the at fault driver?_____

Adjuster_____Phone_____Policy/Claim#_____

Have you retained an attorney?_____ Name_____