

VEHICLE ACCIDENT QUESTIONNAIRE

This information will be strictly confidential. Please print neatly, fill out completely and be as accurate as you can.

PRINT FULL NAME		NAME YOU GO BY	TODAY'S DATE	
STREET ADDRESS		CITY	STATE	ZIP

INSURANCE INFORMATION

DID YOU NOTIFY YOUR INSURANCE CO.? YES <input type="checkbox"/> NO <input type="checkbox"/>		DO YOU HAVE MED-PAY? YES <input type="checkbox"/> NO <input type="checkbox"/>	NAME OF YOUR INSURANCE ADJUSTER:	
YOUR INSURANCE COMPANY		POLICY #	CLAIM #	TELEPHONE #
NAME OF OTHER VEHICLE'S DRIVER	OTHER VEHICLE'S INSURANCE COMPANY		ADJUSTER'S NAME	TELEPHONE #
POLICY #	CLAIM #	WHICH INSURANCE ARE WE FILING CLAIMS WITH?	NAME OF YOUR VEHICLE'S DRIVER	

ACCIDENT INFORMATION

GIVE DETAILS OF HOW ACCIDENT OCCURRED:

DATE AND TIME OF ACCIDENT: <input type="checkbox"/> AM <input type="checkbox"/> PM	WERE POLICE NOTIFIED? YES <input type="checkbox"/> NO <input type="checkbox"/>	ACCIDENT REPORTED TO INSURANCE? YES <input type="checkbox"/> NO <input type="checkbox"/>	DO YOU HAVE AN ATTORNEY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
ATTORNEY NAME	ADDRESS	CITY	STATE, ZIP	TELEPHONE #
YOUR VEHICLE WAS STRUCK FROM THE: Front <input type="checkbox"/> Back <input type="checkbox"/> Driver's Side <input type="checkbox"/> Passenger's Side <input type="checkbox"/>	YOU WERE: Driver <input type="checkbox"/> Passenger: <input type="checkbox"/> In the: Front Seat <input type="checkbox"/> Back Seat <input type="checkbox"/>	WERE YOU USING A SEAT BELT? Yes <input type="checkbox"/> No <input type="checkbox"/>		
NUMBER OF PEOPLE IN YOUR CAR:	APPROXIMATE SPEED OF YOUR CAR:	APPROXIMATE SPEED OF OTHER CAR:		

EXACT AREA(S) OF PAIN IMMEDIATELY AFTER ACCIDENT:

EXACT AREA(S) OF PAIN LATER IN THE DAY OF THE ACCIDENT:

EXACT AREA(S) OF PAIN THE DAY AFTER THE ACCIDENT:

WERE YOU UNCONSCIOUS? No <input type="checkbox"/> Yes <input type="checkbox"/> ← How long?	WERE YOU TAKEN TO A HOSPITAL? Yes <input type="checkbox"/> No <input type="checkbox"/>	NAME OF HOSPITAL, CITY
WHAT TREATMENT WAS GIVEN?		WHAT DIAGNOSIS WAS GIVEN?
DOCTOR'S NAME:		HOW OFTEN DID YOU SEE THIS DOCTOR?
DOCTOR'S ADDRESS		PHONE:

IF YOU CONSULTED ANOTHER DOCTOR, GIVE NAME, ADDRESS AND PHONE:

ANY PRIOR INJURIES OR SYMPTOMS TO THE SAME AREA(S)? IF YES, PLEASE DESCRIBE

HAS INJURY RESTRICTED YOUR WORK? IF YES, IN WHAT WAY?

BEFORE THIS INJURY, WERE YOU ABLE TO WORK ON AN EQUAL BASIS WITH OTHERS YOUR AGE?

Yes No

SINCE THIS ACCIDENT, ARE YOUR SYMPTOMS:

Improving The Same Getting Worse

Patient Signature

Date