Automobile Accident Questionnaire

Please answer all questions completely and accurately:

Name: _____ Date & Time of accident: _____

Please explain in detail how your accident happened:_____
_____
_____
_____

Were you the □ driver? □ passenger? □ front seat? □ back seat?

Were the police notified? □ Yes □ No

Was a citation issued? □ Yes □ No

To the driver of the other car? □ Yes □ No

To the driver of the car you were in? □ Yes □ No

Where did you feel pain immediately after the accident?

Did you find any bruises following the accident? □ Yes □ No Where? _____

Where were you taken after the accident? _____

Were X-rays taken? □ Yes □ No

Were you given medication? □ Yes □ No What type of medication? _____

Name and address of other physician(s) consulted for injuries sustained in this accident. _____

_____

What was the previous physician's diagnosis? _____

_____

Have you been involved in any previous accidents or injuries to this area? □ Yes □ No

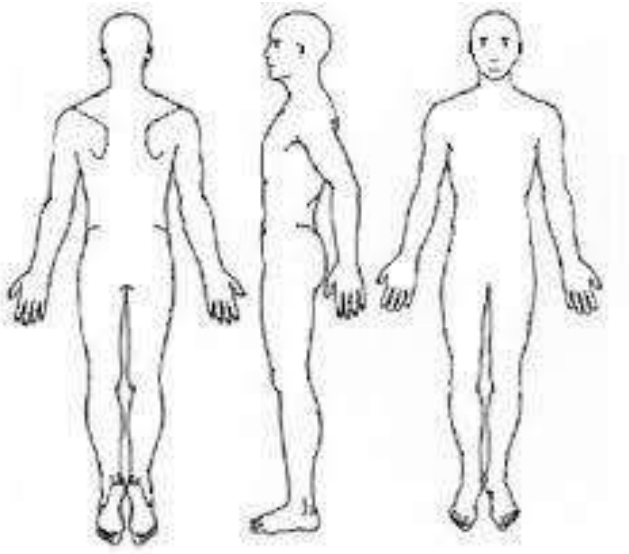
If so, when and extent of injuries. _____

_____

Have you lost any time from work due to these injuries? □ Yes □ No if so, what dates_____

Since your accident, are your symptoms □ Improving □ Getting Worse □ Same

Please mark your areas of pain on the figures below:



Check the symptoms you have since the accident:

Eye, Ear, Nose & Throat

- Sore Throat
- Hoarseness
- Vision Problems
- Ear Pain
- Ear Noises
- Hearing Loss
- Nose Pain
- Nose Bleeding
- Difficulty breathing thru nose
- Dental problems
- Sore mouth
- Difficult speech

Gastro-Intestinal

- Difficult swallowing
- Nausea
- Vomiting blood
- Weight change

Musculo-skeletal

- Headaches
- Neck pain
- Shoulder pain
- Arm pain
- Pain between shoulders
- Mid back pain
- Low back pain
- Leg problems
- Sore muscles
- Stiff joints
- Painful joints
- Weak muscles
- Walking problems
- Broken bones

Cardio-Vascular-Respiratory

- Chest pain
- Difficult breathing
- Rapid heartbeat
- Blood pressure change

Genito-Urinary

- Any changes
- Are you pregnant?
    - Yes
    - No

Nervous System

- Numbness
- Tingling
- Paralysis
- Dizziness
- Fainting
- Headaches
- Muscle jerk
- Convulsions
- Forgetfulness
- Confusion
- Depression
- Insomnia
- Nervousness

Necessary insurance information:

Have you retained an Attorney? □ Yes □ No

Attorney's name: _____ Address: _____

_____ Phone#: (_____) _____ - _____

Your insurance company name and address: _____

_____

Your insurance policy # _____ Claim# _____

Your insurance adjuster's name: _____

Do you have personal injury protection coverage? □ Yes □ No

If you do have personal injury protection, it is our policy to bill your insurance carrier for your services, thus preventing accumulation of finance charges to your account.

If you do not have personal injury protection, other financial arrangements can be made.

The other parties' Insurance name and address: _____

_____

Adjuster's name: _____

Policy# _____ Claim# _____

If you were a passenger involved in the accident, please complete the following:

Name of person driving: _____

Insurance company name and address: _____

_____

Driver's policy # _____ Driver's Claim # _____

Driver's insurance adjuster name: _____

_____
Patients Signature

_____
Date