Automobile Accident Questionnaire

Patient_____ Date_____
No._____ Sex_____Martial Status_____
Date of Birth_____ Home Phone_____
Address_____ City_____
State_____ Zip_____ Occupation_____
Type of work you do (labor)_____
Who referred you to our office? _____Social Sec. #_____
Business phone_____ Company Name_____
Company Address_____
Please explain in detail how your injury happened? _____
_____
Driver of other vehicle (if any)_____
Name of person who has made contact with you_____
Insurance Company_____
Policy #_____ Claim #_____
Name of driver of vehicle in which you were injured (self or other)_____
Insurance Company_____
Policy #_____ Claim #_____
Name of person who has made contact with you_____
Have you retained an attorney? ❒ Yes ❒ No ❒ Not yet
Give time and date present injury occurred _____ ❒ AM ❒ PM _____/_____ /_____
You were heading? ❒ North ❒ South ❒ East ❒ West on_____
Number of people vehicle_____
Were police notified? ❒ Yes ❒ No Did your head strike windshield or object? ❒ Yes ❒ No
Were you knocked unconscious? ❒ Yes ❒ No If yes, for how long_____
You were struck from? ❒ Driver ❒ Passenger ❒ Front seat ❒ Back Seat ❒ Using seat belts
❒ other protective devise
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?_____
What treatment was 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 had and complaints in the involved area before? ❒ Yes ❒ No
If Yes, 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 the accident? ❒ Yes ❒ No
Since the injury, are your symptoms… ❒ improving? ❒ getting worse? ❒ the same?