

# AUTOMOBILE ACCIDENT QUESTIONNAIRE

~ Please answer all questions completely ~

*DEAR PATIENT: This information is considered confidential. Please be as neat and accurate as possible. Thank you.*

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_ PATIENT #: \_\_\_\_\_

PATIENT'S AUTO INSURANCE CO.: \_\_\_\_\_  
POLICY #: \_\_\_\_\_ CLAIM #: \_\_\_\_\_  
NAME OF YOUR INSURANCE ADJUSTER: \_\_\_\_\_  
PHONE #: \_\_\_\_\_ FAX #: \_\_\_\_\_

NAME OF DRIVER OF OTHER VEHICLE : \_\_\_\_\_ PHONE #: \_\_\_\_\_  
OTHER DRIVER INSURANCE CO.: \_\_\_\_\_ PHONE #: \_\_\_\_\_  
INSURANCE ADJUSTER: \_\_\_\_\_  
POLICY #: \_\_\_\_\_ CLAIM #: \_\_\_\_\_

Name of driver of vehicle if you were a passenger: \_\_\_\_\_  
Other drivers insurance company: \_\_\_\_\_ Policy #: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Insurance adjuster: \_\_\_\_\_ Claim #: \_\_\_\_\_

HAVE YOU RETAINED AN ATTORNEY? ( ) YES ( ) NO  
ATTORNEY NAME: \_\_\_\_\_ PHONE #: \_\_\_\_\_

DATE OF ACCIDENT: \_\_\_\_\_ TIME OF ACCIDENT \_\_\_\_\_ CITY & STATE \_\_\_\_\_

You were heading: North ( ) South ( ) East ( ) West ( )  
On (street or highway) \_\_\_\_\_  
Other vehicle was heading: North ( ) South ( ) East ( ) West ( )  
On (street or highway) \_\_\_\_\_  
Road conditions at the time of accident: Wet ( ) Dry ( ) Icy ( ) Other ( )  
Did the police come to the accident scene? Yes ( ) No ( )  
Were you taken to the hospital? Yes ( ) No ( )  
If yes, what hospital? \_\_\_\_\_ How did you get to hospital? \_\_\_\_\_  
What parts of your body were x-rayed at the hospital? \_\_\_\_\_  
What treatment was given? \_\_\_\_\_  
What was the diagnosis? \_\_\_\_\_  
Was another doctor consulted after your accident? Yes ( ) No ( ) Doctor's name: \_\_\_\_\_  
What treatment was given? \_\_\_\_\_  
What was diagnosis? \_\_\_\_\_

## THE FOLLOWING QUESTIONS PERTAIN TO YOU, THE PATIENT AND THE VEHICLE YOU WERE IN:

Where were you seated in the vehicle? \_\_\_\_\_  
Were you aware of the approaching collision prior to impact, or did the impact catch you by surprise? \_\_\_\_\_  
Did you lose consciousness (black out) upon impact? Yes ( ) No ( )  
If you did lose consciousness, estimate for how long \_\_\_\_\_  
How far is the top of the headrest or seatback from the top of your head (approximately) \_\_\_\_\_ inches above / below  
Were you wearing a seatbelt? Yes ( ) No ( )  
If "yes" was it a lap seatbelt or a shoulder-lap seatbelt? \_\_\_\_\_  
List the year, make, and model of the vehicle you were in: Year \_\_\_\_\_; make \_\_\_\_\_; model \_\_\_\_\_  
Was your car stopped at the time of impact? Yes ( ) No ( )  
If "yes" was the driver's foot also on the brake? Yes ( ) No ( )  
If "no" please estimate the speed of the vehicle you were in \_\_\_\_\_ m.p.h.

**CONTINUED: QUESTIONS PERTAINING TO THE PATIENT AND THE VEHICLE:**

If the vehicle was moving at the time of impact, was it:

- |                                      |           |          |
|--------------------------------------|-----------|----------|
| Slowing down?                        | Yes (___) | No (___) |
| Gaining speed?                       | Yes (___) | No (___) |
| Traveling at a steady rate of speed? | Yes (___) | No (___) |

**Please describe in detail, to the best of your knowledge, what happened during this accident:**

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What bleeding cuts did you get during this accident? \_\_\_\_\_

What bruises did you get during this accident? \_\_\_\_\_

On what part of the auto did the following body parts hit:

- Head hit \_\_\_\_\_
- Chest hit \_\_\_\_\_
- Right/left shoulder hit \_\_\_\_\_
- Right/left arm hit \_\_\_\_\_
- Right/left hip hit \_\_\_\_\_
- Right/left leg hit \_\_\_\_\_
- Right/left knee hit \_\_\_\_\_
- Other \_\_\_\_\_

What is the cost damage to the vehicle you were in? \_\_\_\_\_

What of the following car parts broke during the accident:

- Windshield (\_\_\_)      Front seat back (\_\_\_)      Right/left side window (\_\_\_)      Steering wheel (\_\_\_)
- Other: \_\_\_\_\_

Was the trunk of your body pointed straight forward at the time of collision?      Yes (\_\_\_)      No (\_\_\_)

If "no", which direction was it turned and by how much? \_\_\_\_\_

**THE FOLLOWING QUESTIONS PERTAIN TO THE OTHER VEHICLE INVOLVED IN THE ACCIDENT:**

What is the year, make, and model of the other vehicle?

Year \_\_\_\_\_      Make \_\_\_\_\_      Model \_\_\_\_\_

Was the other vehicle moving at the time of the collision?      Yes (\_\_\_)      No (\_\_\_)

If "yes", what was its approximate speed? \_\_\_\_\_ m.p.h.

If the other vehicle was moving at the time of collision, was it:

- Slowing down?      Yes (\_\_\_)      No (\_\_\_)
- Gaining speed?      Yes (\_\_\_)      No (\_\_\_)
- Traveling at a steady rate of speed?      Yes (\_\_\_)      No (\_\_\_)