Auto Accident Questionnaire

Personal Information

Name: ____________________________ Today's Date: _______________________________

Phone: ___________________________ SS#: _______________________________________

Insurance Information

Auto Insurance Company: ____________________ Claim#: ______________________________

Adjustor/Rep and phone number:
____

Name on Policy: ____

Party at Fault: (Please Circle) **Self** or **Other**/Name: ____

Address: ____

City: _________________________ State: _________ Zip: ___________________________

Your Attorney's Information (if applicable)

Name: _______________________________ Phone: ______________________________

Address: ____

City: ______________________________ State: _______ Zip: _____________________

Accident Description

Date of the accident: ___________________ Time of accident: ______________ am / pm

Who else have you received care from **as a result of** this accident:
____
____

What problems/complaints have occurred **due to this accident**:
____
____

Is there anything else you think the doctor should know:
____
____
____

Please Answer the Following Regarding **Your Details** in the Accident:

Approximate Vehicle Speed: ______mph

Your Role
- ◯ Driver
- ◯ Front passenger
- ◯ Rear passenger
- ◯ Motorcycle operator
- ◯ Motorcycle passenger
- ◯ ATV operator
- ◯ ATV passenger

Your Vehicle
- ◯ Subcompact
- ◯ Compact
- ◯ Mid-size
- ◯ Full-size
- ◯ Car
- ◯ SUV
- ◯ Truck
- ◯ Motorcycle

Vehicle Struck
- ◯ Another vehicle
- ◯ By another vehicle
- ◯ A stationary object
- ◯ Multiple impacts
- ◯ ______

Air Bags
- ◯ Deployed
- ◯ Did not deploy

Struck During Impact
- ◯ Steering wheel
- ◯ Air bag
- ◯ Dashboard
- ◯ Rear-view mirror
- ◯ Windshield
- ◯ Car interior
- ◯ ______

Moment of Impact
- ◯ Tensed body
- ◯ Neck whipped
- ◯ Spine (back) twisted
- ◯ Thrown over seat
- ◯ Thrown side to side
- ◯ Pinned by vehicle
- ◯ ______

Travel Direction
- ◯ North
- ◯ South
- ◯ East
- ◯ West

Collision Location
- ◯ Head On
- ◯ Front
- ◯ Behind
- ◯ Passenger's Side
- ◯ Driver's Side

Patient Conscious
- ◯ Lost consciousness
- ◯ Did not lose consciousness

Medical Attention
- ◯ Received on scene
- ◯ Not recevied at site

Patient Went To
- ◯ This office
- ◯ Hospital
- ◯ Personal doctor
- ◯ Home
- ◯ Work
- ◯ Resumed activities

Were You Wearing a Seat Belt During the Accident? (Please Circle) **Yes** or **No, Shoulder Belt** or **Lap Belt**

Please Answer the Following Regarding the **Other Parties Details** in the Accident:

Approximate Vehicle Speed: ______mph

Other Vehicle Description
- ◯ Subcompact
- ◯ Compact
- ◯ Mid-size
- ◯ Full-size
- ◯ Car
- ◯ SUV
- ◯ Truck
- ◯ Motorcycle

Other Vehicle Direction
- ◯ North
- ◯ South
- ◯ East
- ◯ West

Please Answer the Following Regarding the **Details of the Accident Itself**:

Road Conditions
- ◯ Dry
- ◯ Damp
- ◯ Wet
- ◯ Snow
- ◯ Icy
- ◯ ______

Time of Day
- ◯ Daylight
- ◯ Dawn
- ◯ Dusk
- ◯ Night
- ◯ ______

Street the Accident Happened On:

____

State the Accident Happened In:

____

Name: ____ **Date:** ____________________