AUTOMOBILE ACCIDENT QUESTIONNAIRE

Dear Patient: This information is considered confidential. In order for us to understand your condition properly, please be as neat and accurate as possible while completing this form. Thank you.

Name ____ Date ______________

Please explain in detail how your accident happened ________________________________

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Give time and date present injury occurred ____________ □ AM □ PM ________________ 20____

You were heading □ North □ South □ East □ West on ______________________ (street or highway)

Were police notified? □ Yes □ No

Were you knocked unconscious? □ Yes □ No If so, for how long? ______________________

You were struck from □ Behind □ Front □ Left Side □ Right Side

You were □ Driver □ Passenger □ Front Seat □ Back Seat □ Using seat belts □ Other protective devices

Where did you feel pain immediately after the accident? ______________________________

Were you taken to the hospital after the accident? ________________________________

What treatment was given? ____

Was any other doctor consulted after your accident? □ Yes □ No

If so, give doctor's name ______________________________ □ D.C □ M.D. □ D.O. □ D.D.S.

Doctor's diagnosis ____

What treatments did you receive? ____

Have you ever had any complaints in the involved area before? □ Yes □ No

If so, what were the complaints? ____

Before the injury, were you capable of working on an equal basis with other your age? □ Yes □ No

Are your work activities restricted as a result of this accident? □ Yes □ No

Since this injury are your symptoms □ improving? □ getting worse? □ the same?

Name of your insurance adjuster ____

Have you hired an attorney? □ Yes □ No

If so, name and address ____

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