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AUTO ACCIDENT HISTORY AND QUESTIONNAIRE

Please print clearly.

Today's date (mm/dd/yyyy)

Name (Last, First, Middle initial) **Gender** ○ Male ○ Female **Social Security number**

Birth date (mm/dd/yy) **Age** **Date and time of the accident** **Where was the accident? (City/State)**

Describe in your own words how the accident occurred

(Cont.)

Was a police report filed? ○ Yes ○ No **How many vehicles were involved in the accident?** **Your vehicle model and make** **Other vehicle(s) model and make**

What direction were you traveling and on which street? **What direction was the other vehicle traveling and on which street?**

Did you anticipate the impact or were you caught by surprise? **Did you have a seat belt on?** ○ Yes ○ No **W/shoulder harness?** ○ Yes ○ No

Did you brace your arms/hands against any part of the vehicle? ○ Yes ○ No **If yes, what part?**

Did you brace your legs against the floorboard? ○ Yes ○ No **Was your foot on the break?** ○ Yes ○ No

At the time of impact were you ○ Looking forward ○ Looking left ○ Looking down ○ Looking right ○ Looking up

What was the position of your torso at the time of impact? ○ Straight forward ○ Rotated right ○ Rotated left

Did any other part of your body hit the interior of the vehicle? ○ Yes ○ No **If yes, what or where?**

What kind of headrest was in your seat? ○ Moveable (HI pos MED pos LOW pos) ○ Non-moveable ○ None

Did your hat/glasses fall from your head during the accident? ○ Yes ○ No

What portion of your car was impacted? ○ Rear ○ Front ○ Right side ○ Left side

During and after the crash, what happened to your vehicle? ○ Kept going straight ○ Kept going straight hitting car in front ○ Was hit by another car ○ Spun around ○ Spun around and hit a stationary object ○ Hit a stationary object ○ Other_____

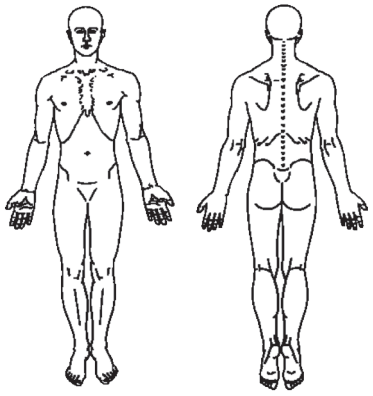
Your vehicle: ○ In park ○ In gear ○ Stopped ○ In neutral ○ Moving _____ MPH

Other vehicle #1: ○ In park ○ In gear ○ Stopped ○ In neutral ○ Moving _____ MPH

Other vehicle #2: ○ In park ○ In gear ○ Stopped ○ In neutral ○ Moving _____ MPH

What are the estimated monetary damages to your vehicle? **Please note any extraordinary damage details**

Where did you immediate notice pain or symptoms? (Please mark with an "x")



Since the accident are your symptoms: ○ Better ○ Worse ○ Same

Where were you located in the vehicle? ○ Driver, ○ Front passenger ○ Rear passenger driver side ○ Rear passenger right side ○ Third seat driver side ○ Third passenger side ○ Center seat

Were you unconscious? ○ Yes ○ No **If yes, for how long?**

Did you go to the hospital/ER after the accident? ◯ Yes ◯ No

Name/location of hospital/ER

When?

Did you go to hospital by ambulance? ◯ Yes ◯ No

If yes, did they use: ◯ Neck brace ◯ Other: ◯ Back brace

If no, where did you go?

Did the ambulance workers give you any medications or supplies? ◯ Yes ◯ No

If you were given medications or supplies, please list them

If you were hospitalized:

Were you there overnight? ◯ Yes ◯ No

What medications did you receive?

Were x rays taken? ◯ Yes ◯ No

If yes, what areas?

What diagnosis was given?

What were the treating doctors' recommendations?

Since the accident have you been to any other doctors? ◯ Yes ◯ No

If yes, name of doctor(s) and location

What was their diagnosis?

Did they recommend any treatment?

What medications or treatments have you received?

Have you ever had similar symptoms in the past? ◯ Yes ◯ No

If yes, please explain

Have you lost any days from work? ◯ Yes ◯ No

If so, how many and dates

What is your occupation?

What are your job requirements?

Is there anything else you'd like us to know? Please use the space below.

Signature

Date