Automobile Accident Questionnaire

Patient Name: ____ Date of accident: ____

What are your injuries or conditions resulting from this accident? ____
____
____

Any prior history of injuries to the same extremity? ☐ Yes ☐ No

Were you the: ☐ Driver ☐ Front Seat Passenger ☐ Back Seat Passenger
☐ Other (please explain): ____

Were you wearing your seatbelt? ☐ Yes ☐ No

Make & model of vehicle you were occupying: ____

Brief description of accident: ____
____
____

Vehicle motion at impact: ☐ High speed ☐ Low speed ☐ At a complete stop

Did the airbags deploy? ☐ Yes ☐ No

Head trauma or loss of consciousness? ☐ Yes ☐ No

How did you exit the vehicle? ☐ Under my own power ☐ By EMS/fire rescue

Were you taken to an emergency room? ☐ Yes ☐ No. If yes, which one? ______________________

Treatment to date for accident. Please describe: ____
____

The onset of pain was: ☐ Immediate ☐ Next day ☐ Progressive over next week

Diagnostic studies to date: ☐ X-Rays ☐ MRI ☐ CT Scan ☐ Bone Scan
What Facility? ____

Are you being represented by an attorney for your injuries related to this accident? ☐ Yes ☐ No

If so, please provide attorney's name and contact phone number:

Attorney name: __________________________________ Contact Phone: _____________________________

Patient signature: ________________________________ Date: _____________________________________

Reviewed by: ___________________________________ Date: _____________________________________

709 S. Harbor City Boulevard, Suite 100, Melbourne, Florida 32901 | Office: (321) 725-2225 | Fax: (321) 308-0635
Email: info@myfcmg.com | Web: www.myfcmg.com