VEHICLE ACCIDENT QUESTIONAIRE

This information will be strictly confidential. **Please print neatly, fill out completely and be as accurate as you can.**

PRINT FULL NAME	NAME YOU GO BY	TODAY'S DATE
STREET ADDRESS	CITY	STATE / ZIP

INSURANCE INFORMATION

DID YOU NOTIFY YOUR INSURANCE CO.? YES☐ NO☐	DO YOU HAVE MED-PAY? YES☐ NO☐	NAME OF YOUR INSURANCE ADJUSTER:

YOUR INSURANCE COMPANY	POLICY #	CLAIM #	TELEPHONE #
NAME OF OTHER VEHICLE'S DRIVER	OTHER VEHICLE'S INSURANCE COMPANY	ADJUSTER'S NAME	TELEPHONE #

POLICY #	CLAIM #	WHICH INSURANCE ARE WE FILING CLAIMS WITH?	NAME OF YOUR VEHICLE'S DRIVER

ACCIDENT INFORMATION

GIVE DETAILS OF HOW ACCIDENT OCCURRED:

DATE AND TIME OF ACCIDENT: □AM □PM	WERE POLICE NOTIFIED? YES☐ NO☐	ACCIDENT REPORTED TO INSURANCE? YES☐ NO☐	DO YOU HAVE AN ATTORNEY? YES☐ NO☐

ATTORNEY NAME	ADDRESS	CITY	STATE, ZIP	TELEPHONE #

YOUR VEHICLE WAS STRUCK FROM THE: Front☐ Back☐ Driver's Side☐ Passenger's Side☐	YOU WERE: Driver☐ Passenger: ☐ In the: Front Seat☐ Back Seat☐	WERE YOU USING A SEAT BELT? Yes☐ No☐

NUMBER OF PEOPLE IN YOUR CAR:	APPROXIMATE SPEED OF YOUR CAR:	APPROXIMATE SPEED OF OTHER CAR:

EXACT AREA(S) OF PAIN IMMEDIATELY AFTER ACCIDENT:

EXACT AREA(S) OF PAIN LATER IN THE DAY OF THE ACCIDENT:

EXACT AREA(S) OF PAIN THE DAY AFTER THE ACCIDENT:

WERE YOU UNCONSCIOUS? No☐ Yes☐ ⇐ How long?	WERE YOU TAKEN TO A HOSPITAL? Yes☐ No☐	NAME OF HOSPITAL, CITY

WHAT TREATMENT WAS GIVEN?	WHAT DIAGNOSIS WAS GIVEN?
DOCTOR'S NAME:	HOW OFTEN DID YOU SEE THIS DOCTOR?
DOCTOR'S ADDRESS	PHONE:

IF YOU CONSULTED ANOTHER DOCTOR, GIVE NAME, ADDRESS AND PHONE:

ANY PRIOR INJURIES OR SYMPTOMS TO THE SAME AREA(S)? IF YES, PLEASE DESCRIBE

HAS INJURY RESTRICTED YOUR WORK? IF YES, IN WHAT WAY?

BEFORE THIS INJURY, WERE YOU ABLE TO WORK ON AN EQUAL BASIS WITH OTHERS YOUR AGE?	SINCE THIS ACCIDENT, ARE YOUR SYMPTOMS:
Yes☐ No☐	Improving☐ The Same☐ Getting Worse☐

_____ _____

Patient Signature Date