Automobile Insurance Information

Patient's Name: _____ Date of Injury: _____

Name of *Your* Automobile Insurance Company: _____

Address: _____ City: _____ State: _____ Zip: _____

Adjustor's Name: _____ Phone Number: _____

Do you have PIP Coverage? Y/N Unknown Claim Number: _____

Name of Policy Owner: _____ Driver of Your Car: _____

Name of Other Party's Insurance Company: _____

Address: _____ City: _____ State: _____ Zip: _____

Name of Policy Owner: _____ Driver of Other Car: _____

Did the police come to the scene of the accident? Y/N If yes, please provide a copy of the policy report.

Attorney Information

Is an attorney representing you for this case? Y/N

Name of Attorney: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Your Health Insurance

Name of Health Insurance Company: _____

Address: _____ City: _____ State: _____ Zip: _____

Name of Insured: _____ Insured's ID: _____

Group Name/Number: _____

Automobile Accident Questionnaire

Name: _____ Date: _____

This questionnaire will allow you to describe your automobile accident in detail. Please complete it carefully as the information that you provide will assist the doctor in evaluating and documenting your injuries. Check any and all answers that apply.

What was the date of the accident? _____

What was the model & make of the vehicle you were in? _____

Where inside the vehicle were you sitting at the time of the impact?

□ Driver
□ Front Passenger
□ Left Rear Passenger
□ Right Rear Passenger
□ Middle Rear Passenger
□ Other _____

From which direction was your vehicle impacted?

□ the rear
□ head on
□ the left side
□ the right side
□ obliquely from front left side
□ obliquely from front right side
□ obliquely from rear left side
□ obliquely from rear right side

At the time of impact, were you wearing:

□ a lap & shoulder belt
□ a lap belt only
□ was not wearing any type of seat belt

What was the make & model of the other vehicle/s in the accident? _____

How would you rate the damage to your vehicle?

□ minimal
□ moderate
□ extensive
□ a total loss
□ unsure

Were the police called to the scene? □ yes □ no

Immediately following the accident, did you feel any of the following? (check all that apply)

□ disoriented
□ confused
□ fine immediately afterwards
□ some pain in the neck
□ some pain in the mid back
□ some pain in the low back

(continued)

After the accident, what did you do?

□ drove myself home □ was driven home □ drove myself to the ER □ was driven to the ER

When did your symptoms begin?

□ immediately
□ shortly afterwards
□ later that day
□ the next day
□ other _____

Did you sustain any bruises or cuts? □ none □ minor □ severe

If so, where on your body? _____

Did your hit your head on any of the following?

□ steering wheel
□ dashboard
□ windshield
□ side window
□ back of front seat
□ none
□ not sure
□ other _____

What direction was your head pointed at the time of impact?

□ straight ahead
□ to the right
□ to the left

What direction was your torso pointed at the time of impact?

□ straight ahead
□ to the right
□ to the left

Did you experience any of these symptoms prior to the accident?

□ headaches
□ neck pain
□ upper back pain
□ mid back pain
□ low back pain
□ shoulder pain
□ hip pain
□ none
□ other _____

Have you sought any other medical treatment for your injuries? □ yes □ no
If yes, please give their name and location.

□ medical doctor _____
□ chiropractor _____
□ physical therapist _____
□ massage therapist _____
□ other _____