Accident Questionnaire

Please answer all questions completely

Name____ Date of Birth______________________ Home Phone_________________________

Address____City________________________ State _________Zip_____________________

Please explain in detail how your accident happened____

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Your Insurance Co.____________________________Policy No.______________________Claim No.___________________________________

Driver of other vehicle (if any)

Name____ Insurance Company__________________________Policy No._____________________________

Name of your insurance adjuster__________________________________ Adjuster's phone Number ___________________________________

Have you retained an attorney? Yes No If so, attorney's name and address____

____Atty Phone______________________________

You were heading North East South 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 device?_____________

What were the time and date of present injury?____

Where did you feel pain immediately after the accident?____

Where were you taken to a Dr.'s office or hospital?____

If so, what was the Dr.'s name, and what treatment was given?____

Was any other doctor consulted after your accident? Yes No

If so, what was the Dr.'s name? _____________________________________ D.C., M.D., D.O., D.D.S

What was the diagnosis? ____

What treatment was given? ____

How often did you see the doctor? ____

How long did you see the doctor? ____

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 others 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? Same?

Please sign and date ____ Date __________________________