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_____

_____

_____

_____

_____

Your Insurance Co._____Policy No._____Claim No._____

Name of your insurance adjuster_____ Your adjuster's phone Number _____

Driver of other vehicle (if any)

Name_____Insurance Company_____Claim No._____

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 _____