Automobile Accident Questionnaire

Please answer all questions as completely as possible

Check symptoms you have noticed since the accident:

☐ Headache	☐ Dizziness	☐ Depression	☐ Fatigue
☐ Upset Stomach	☐ Eye Light Sensitivity	☐ Buzzing in Ears	☐ Diarrhea
☐ Neck Pain	☐ Head Feels Heavier	☐ Loss of Memory	☐ Cold Feet
☐ Stiff Neck	☐ Pins and Needles in Arms	☐ Ringing Ears	☐ Cold Hands
☐ Hip pain	☐ Pins and Needles in Legs	☐ Loss of Balance	☐ Back Pain
☐ Face Flushed	☐ Sleeping Problems	☐ Constipation	☐ Tension
☐ Nervousness	☐ Numbness in Fingers	☐ Loss of Smell	☐ Fever
☐ Irritability	☐ Numbness in Toes	☐ Loss of Taste	☐ Chest Pain
☐ Cold Sweats	☐ Shortness of Breath	☐ Dazed	☐ Fainting
☐ Anxiety	☐ Fear of being in a car	☐ Migraine	☐ Palpitations

Any other symptoms than the ones listed above? _____
Were you taken to the hospital after the accident? ☐ Yes ☐ No -Were you admitted? ☐ Yes ☐ No -For how long? _____
Name of Hospital _____ Name of Attending Doctor_____
What was the diagnosis? _____
What treatment was given? _____
Was any other doctor consulted after your accident? ☐ Yes ☐ No -Doctors name and Specialty _____
What was the diagnosis? _____ What treatment was given? _____
How often and for how long did you see the doctor? _____
Have you ever had any complaints in the area involved before the accident? ☐ Yes ☐ No
If yes, what were the complaints? _____
Since the injury are your symptoms - ☐ Improving? ☐ Same? ☐ Getting Worse?
Before the accident were you capable of working on equal basis with others your age? ☐ Yes ☐ No
Have you lost any time from work due to your injuries? ☐ Yes ☐ No -If yes, how long? _____
Are your work duties restricted as a result of this accident? ☐ Yes ☐ No -What restrictions? _____
Have you had any previous accidents or injuries? ☐ Yes ☐ No Is there any pain from the previous accident/injury? ☐ Yes ☐ No
Description of previous accidents or injuries: _____
What was your position in the vehicle? ☐ Driver ☐ Passenger
If Driver were your hands on the steering wheel? ☐ Yes ☐ No -Which hands? ☐ Left ☐ Right ☐ Both
If Passenger, were you sitting in ☐ Front ☐ Right Rear ☐ Center Rear ☐ Left Rear
Were you wearing a seat belt? ☐ Yes ☐ No -Were police notified? ☐ Yes ☐ No
Did your vehicle strike another vehicle? ☐ Yes ☐ No -Was your vehicle struck by another vehicle? ☐ Yes ☐ No
Did your vehicle strike an object or person? ☐ Yes ☐ No -Explain what or who it struck _____
You were heading ☐ North ☐ South ☐ East ☐ West -On what street? _____
The other vehicle was heading ☐ North ☐ South ☐ East ☐ West -On what street? _____
Did you brace for impact? ☐ Yes ☐ No -Which way was your body facing at the time of impact? ☐ Straight ahead ☐ Left ☐ Right
Did the seat back bend or break? ☐ Yes ☐ No
Did you strike anything in the vehicle at the time of impact? ☐ Yes ☐ No
If yes, specify what part of your body struck what: (i.e. head struck window; arm struck steering wheel, etc.)

☐ Steering Wheel _____	☐ Dashboard _____	☐ Roof _____
☐ Right Side Door _____	☐ Windshield _____	☐ Right Window _____
☐ Left Side Door _____	☐Left Window_____	☐ Another Person _____

☐ Other _____
Were you knocked unconscious? ☐ Yes ☐ No -If yes, for about how long? _____
Your vehicle was struck from ☐ Behind ☐ Front ☐ Left Side ☐ Right Side
Name of driver (if you were NOT driving the vehicle): _____ Drivers Phone #: _____
Drivers Insurance Company: _____ Policy #: _____
Name of driver of OTHER vehicle: _____ Insurance Company: _____
Policy #: _____ Claim #: _____
Name of YOUR insurance adjustor: _____ Phone #: _____
Have you retained an attorney? ☐ Yes ☐ No -If yes, Attorney's Name: _____
Attorney's Address and Phone #: _____

Patients Signature: _____ Date: _____

Guardian or Spouse's Signature: _____ Date: _____

……..……DO NOT WRITE BELOW THIS LINE……..……..

Doctors Signature: _____