Accident Questionnaire

Name ____ Date ______________________

Date and time of accident: ____

Where did you feel pain? ____

Other doctors consulted since your accident: _______________________________

Type of treatment received:____

Have you retained an attorney? Yes ______ No _____

If yes, please give: Name: ____

Address: ___________________________ City/State/Zip:______________________

Phone No.: ___________________

PLEASE EXPLAIN FULLY HOW YOUR ACCIDENT HAPPENED

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Please circle which answer applies in the following:

You were: Driver Passenger in: Front seat Back seat right Back seat left

Seat belts: yes no

Type of vehicle: Auto: large mid economy / Truck: large mid small

Approximate speed: Your vehicle ______mph / Other vehicle _____mph

Your vehicle was: parked stopped slowing down beginning to accelerate other

Your head was: looking straight turned left right

Your vehicle: struck another vehicle? yes no

If yes, what part of your vehicle contacted:

Reason: ____

If your vehicle was struck by another vehicle:

Type of vehicle: _______________________ Struck from: front back side left right

The part of your vehicle that was hit: _______________

______Estimate of damages: $___________

At the moment of impact, did any part of your body (head, face, shoulder, knee, etc.)

strike any part of the inside of your car? Yes No If yes, explain:

____Wer

e you rendered unconscious? Yes No How long until you regained

consciousness? Number of: minutes_______ hours _______ days

How did you emotionally feel following the accident? (e.g., badly shaken, upset, panicky,

etc.):____

Was your seat broken by the impact? Yes No

How long until you started feeling pain or discomfort? immediately? yes no

# of ___ minutes ___ hours __days ___weeks

Were your first symptoms? mild moderate severe

Did your pain and discomfort worsen from the initial onset? Yes No

Over how long a period? minutes hours days weeks

Were you transported to the hospital or an Emergency center? Yes No

Name of hospital or facility: ____

Were you transported by: ambulance self other ______________

Have you ever been involved in a similar accident? Yes No

If Yes, when? ______________________

Have you ever had the same or similar symptoms? Yes No

If Yes, how long have you been pain free? __________________________

Did you have any symptoms at the time of the accident? Yes No

If so, what were the symptoms? ___________________________________

Type of work you do: ____

Company: ____

Number of years employed in this type of work: ____________

At work, do you sit or stand most of the time? ______________________________

What activities? Stand Sit Bend Lift Twist Stretch Reach Stoop

Crawl

Thank You for Completing Both Sides of the Accident Questionnaire