AUTOMOBILE ACCIDENT QUESTIONNAIRE

Patient's Name:_____ Today's Date:_____ Date of Accident: _____

THE FOLLOWING QUESTIONS PERTAIN TO YOU AND THE VEHICLE YOU WERE IN:

Your position in the vehicle:
❑Driver ❑Front Passenger ❑Pedestrian ☐Bicycle ☐Motorcycle ❑Rear Location ❑Left ❑Middle ❑Right

Your Vehicle Make/Model: _____

Was your vehicle moving or stopped:
❑Proceeding along ❑Stopped ❑Stopped at intersection ❑Making a Right ❑Stopped in Traffic ❑Making a Left
❑Slowing down ❑Stopped at light ❑ Stopped at stop sign ❑Parking ❑Accelerating ❑Pedestrian

Collision Type:
❑Rear ❑Front ❑ Left Front ❑Left Rear ❑ Right Front ❑ Right Rear
❑ Front Passenger side door ❑Back Passenger Side door ❑Front driver side door ❑Back driver side door

Other Vehicle Make/Model: _____

Visibility: ☐Poor ☐Fair ☐Good **Road Conditions:** ❑Clean and dry ❑Wet ❑Icy

THE FOLLOWING QUESTIONS CONCERN THE MOMENT OF IMPACT OF THE ACCIDENT:

Were you...
❑Totally unaware that the accident was impending
❑Aware that the accident was impending
❑Aware that the accident was impending and braced for it

Restraints: (check all that apply)
❑Lap belt only
❑Seat belt/shoulder harness
❑No restraints

Did you lose consciousness?❑Yes ❑No **Did the airbags deploy?** ❑Yes ❑No

Damage to vehicle YOU were in:
❑Incurred minimal ❑Incurred moderate damage ❑amount of damage $_____

AS A RESULT OF THE FORCE OF THE COLLISION, DID YOUR BODY HIT ANYTHING INSIDE THE CAR?

_____

_____

Have you been seen at any other doctor or Emergency room as a result of this accident? ☐ Yes ☐ No

If yes, When? _____ and where? _____ Any xrays, mri or CT? _____
Were you transported to ER in an ambulance ☐ Yes ☐ No

Primary care Physician: _____

Have you lost any time from work or school? Yes No If yes, what date(s)?_____

Auto Ins. Co: _____ **3rd Party Ins. (other vehicle) _____**
Claim # _____ **Claim # _____**
ClaimRep & Tel :_____ **Claim Rep & Tel: _____**

Patient Signature: _____ Date: _____