MOTOR VEHICLE COLLISION/PERSONAL INJURY QUESTIONNAIRE

Please complete this questionnaire to the best of your ability.
THANK YOU.

1. Name and Address: _____
   _____
   _____
2. Phone Number: _____
3. Please describe the collision in your own words: _____
   _____
   _____
   _____
4. Where did the collision occur? (Town/City, State): _____
5. Date of collision: _____ Time: _____ AM/PM
6. Were you the: ❑ Driver ❑ Passenger ❑ Pedestrian ?
7. If passenger, were you in the: ❑ Front Seat ❑ Passenger Rear Seat ❑ Driver Rear Seat ?
8. What type of vehicle were you in? *(body style, year, make, model)*: _____
9. What type was the other vehicle(s) involved? *(body style, year, make, model)*: _____
   _____
10. Did your vehicle strike the other vehicle? ❑ Yes ❑ No
11. Was your car struck by the other vehicle? ❑ Yes ❑ No
12. What direction was your vehicle going? _____
13. What direction was the other vehicle going? _____
14. Was the impact from the: ❑ Front ❑ Rear ❑ Left Side ❑ Right Side ?
15. What was the approximate speed at the time of the impact?
    Your vehicle *(mph)*:_____ Other vehicle *(mph)*: _____
16. Did the airbag deploy? ❑ Yes ❑ No
17. What was the weather at the time of the collision? ❑ Dry ❑ Wet ❑ Icy
18. Was your vehicle in: ❑ Park ❑ Neutral ❑ In Gear ❑ Moving ❑ Stopped ?
19. Were your brakes being applied? ❑ Yes ❑ No
20. Was your vehicle shoved: ❑ Forward ❑ Backward ❑ Sideways ?
21. Were you shoved: ❑ Forward ❑ Whipped Backward ?
22. Did your seat have a head restraint (headrest)? ❑ Yes ❑ No
23. If yes, what was the position? ❑ Low ❑ Midpostion ❑ High
24. Did your head ride over the headrest? ❑ Yes ❑ No
25. Did your hat/glasses end up in the back seat or rear window? ❑ Yes ❑ No
26. Did any other part of your body hit the interior of the vehicle? ❑ Yes ❑ No
27. If yes, please specify: ❑ Seatbelt Restraints ❑ Steering Wheel ❑ Dashboard ❑ Windshield
    ❑ Side Door ❑ Side Window ❑ Other _____
28. Which part of your body? ❑ Chest ❑ Head ❑ Chin ❑ Face ❑ Right or Left Knee
    ❑ Right or Left Shoulder ❑ Right or Left Hand ❑ Other _____
29. Were you holding on to the steering wheel? ❑ Yes ❑ No
30. Did you brace your arms against the dash? ❑ Yes ❑ No
31. Did you brace your legs against the floorboard? ❑ Yes ❑ No

32. Was your ankle turned? ❑ Yes ❑ No
33. Did the vehicle go into a spin or roll as a result of the impact? ❑ Yes ❑ No
34. If yes, explain: _____
35. How much damage was there to the outside of the vehicle? ❑ None ❑ Some ❑ A lot
36. How much damage was there to the inside of the vehicle? ❑ None ❑ Some ❑ A lot
37. At the point of impact, where did you experience pain? Be specific: _____
_____
_____
38. Immediately after the accident were you: ❑ Conscious ❑ Dazed ❑ Unconscious ?
39. If you lost consciousness, how long? _____
40. Were you wearing a seat belt? ❑ Yes ❑ No
41. Did the belt have a shoulder harness? ❑ Yes ❑ No
42. If yes, did it contribute to the pain you are experiencing? ❑ Yes ❑ No
43. At the time of impact, were you looking: ❑ Straight Ahead ❑ To the Right ❑ To the Left ❑ Down ❑ Up ?
44. Did the seat break as a result of impact? ❑ Yes ❑ No
45. Were you braced for the impact? ❑ Yes ❑ No
46. Were you surprised by the impact? ❑ Yes ❑ No
47. Did you go to the hospital? ❑ Yes ❑ No
48. If yes, when? ❑ After the Accident ❑ Next Day ❑ Other _____
49. If yes, how did you get there? ❑ Ambulance ❑ Other _____
50. If by ambulance, did the ambulance attendants place you in a: ❑ Neck Brace ❑ Back Brace ❑ Other _____
51. Any medication or medical supplies given? _____
52. Did you have x-rays taken at the hospital? ❑ Yes ❑ No
53. If you went to the hospital, please answer the following:
Name of Hospital _____
Name of Doctor _____
Diagnosis _____
Treatment Received _____
_____
54. Have you had any similar problems before? ❑ Yes ❑ No
55. If yes, please explain: _____
56. Are you diabetic? ❑ Yes ❑ No
57. Do you have high blood pressure? ❑ Yes ❑ No
58. Do you have low blood pressure? ❑ Yes ❑ No
59. Do you have arthritis or degenerative joint disease? ❑ Yes ❑ No
60. What type of work do you do? _____
61. What are your job requirements? _____
62. Have you lost any days of work from this injury? ❑ Yes ❑ No
63. If yes, give dates: _____

Patient Signature: _____ Date: _____

Print Name: _____ Date: _____

PERSONAL INJURY INSURANCE COVERAGE

Please complete this questionnaire to the best of your ability.
THANK YOU.

Date: _____ Spoke with: _____ Number: _____
Patient Name: _____
Insurance Company: _____
Address: _____
Phone Number: _____
Insured Name: _____
Date of Accident: _____
Claim Number: _____
Policy Number: _____
Has the accident been reported? ❑ Yes ❑ No
Name of adjuster handling claim: _____

GROUP HEALTH INSURANCE

Please complete this questionnaire to the best of your ability.
THANK YOU.

Insurance Company: _____
Address: _____
Phone Number: _____
Insured Name: _____
Policy#: _____ Phone: _____

ATTORNEY INFORMATION

Please complete this questionnaire to the best of your ability.
THANK YOU.

Date: _____ Spoke with: _____ Number: _____
Patient Name: _____
Attorney Name: _____
Address: _____
Phone Number: _____