

## Auto Accident/Personal Injury Questionnaire

NAME: \_\_\_\_\_ DOB: \_\_\_\_\_  
HOME PHONE: \_\_\_\_\_ CELL: \_\_\_\_\_ WORK: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_  
CITY \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

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DATE OF INJURY: \_\_\_\_\_ CLAIM NUMBER: \_\_\_\_\_  
ADDRESS TO SEND CLAIMS: \_\_\_\_\_

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CLAIM ADJUSTER'S NAME: \_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_

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1. Have you retained an attorney? Yes \_\_\_ No \_\_\_. Name: \_\_\_\_\_
  2. Were there any witnesses? Yes \_\_\_ No \_\_\_. Name(s) \_\_\_\_\_
  3. Date of Accident: \_\_\_\_\_ Time of Day: \_\_\_\_\_
  4. Were you: Driver \_\_\_ Passenger \_\_\_ Front Seat \_\_\_ Back Seat \_\_\_
  5. Number of passengers in vehicle? \_\_\_\_\_. Number of passengers in other vehicle? \_\_\_\_\_
  6. What direction were you headed? (N, S, E, W) Street \_\_\_\_\_
  7. What direction was other vehicle coming? (N, S, E, W) Street \_\_\_\_\_
  8. Were you struck from Behind \_\_\_ Front \_\_\_ Left Side \_\_\_ Right Side \_\_\_?
  9. Were you knocked unconscious? Yes \_\_\_ No \_\_\_ If yes, for how long? \_\_\_\_\_
  10. Were police notified? Yes \_\_\_ No \_\_\_
  11. In your own words please describe the accident: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
  12. What are you PRESENT complaints and symptoms? \_\_\_\_\_
  13. Do you have any congenital (birth) factors, which relate to this problem? Yes \_\_\_ No \_\_\_.  
If yes, please explain: \_\_\_\_\_
  14. Have you been treated by another doctor since the accident? Yes \_\_\_ No \_\_\_. If yes please  
list the doctor's name and address and phone number: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
  15. What kind of treatment did you receive? \_\_\_\_\_
  16. Since this injury occurred, are your symptoms: Improving \_\_\_ Getting worse \_\_\_ Same \_\_\_
  17. Have you lost time from work as a result of this accident? Yes \_\_\_ No \_\_\_. If yes, please  
complete this question.
    - a. Last day worked: \_\_\_\_\_
    - b. Type of employment: \_\_\_\_\_
    - c. Are you being compensated for time lost from work? Yes \_\_\_ No \_\_\_
  18. Do you notice any activity restrictions as a result of this injury? Yes \_\_\_ No \_\_\_. If yes,  
please describe in detail: \_\_\_\_\_
-

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_.

19. Please describe how you felt:

- a. DURING the accident: \_\_\_\_\_
- b. IMMEDIATELY after the accident: \_\_\_\_\_
- c. LATER THAT DAY: \_\_\_\_\_  
THE NEXT DAY: \_\_\_\_\_

20. Did you have any physical complaints prior to the accident? Yes \_\_\_\_ No \_\_\_\_ . If yes please describe in detail: \_\_\_\_\_  
\_\_\_\_\_

21. Do you have any previous illnesses, which relate to this case? Yes \_\_\_\_ No \_\_\_\_ . If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_

22. Have you ever been involved in an accident before? Yes \_\_\_\_ No \_\_\_\_ If yes, please describe, including date(s) and type(s) of accidents, as well as any injuries received. \_\_\_\_\_  
\_\_\_\_\_

23. Is there any other pertinent information: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
\_\_\_\_\_