ACCIDENT/INJURY QUESTIONNAIRE

Name: (Last, First MI)_____ **Today's Date:** _____

AUTOMOBILE ACCIDENT – ADDITIONAL INFORMATION

- **Was anyone else in the vehicle with you? · No · Yes -** *(Number of people)* _____
- **You were? · Front seat –** *Driver / Passenger* **· Rear Seat**– Behind Driver / Middle / Behind Passenger / 2nd Row / 3rd Row
- **Name of Driver**, *if not self*: _____ **Name of Driver of other vehicle:** _____
- **Did airbags deploy? · No · Yes Did Police arrive? · No · Yes Using Seatbelt? · No · Yes**
- **Did you strike the windshield or object in car? · No · Yes -** *(Describe)* _____
- **What direction were you looking? · Right · Left · Straight**
- **Were you knocked unconscious? · No · Yes** *(How long?)* _____
- **Where was your vehicle impacted?** Front / Rear / Passenger Side / Driver's Side / Other: _____
- **Was your vehicle totaled? · No · Yes**
- **Where was the other vehicle impacted?** Front / Rear / Passenger Side / Driver's Side / Other: _____
- **Your vehicle Year**:_____ **Make**:_____ **Model**:_____ **Speed During Collision**:_____
- **Your Auto Ins:** _____ **Policy #:** _____ **Claim #:** _____ **Phone #:**_____
  - **Address:** _____**City:** _____ **State:** _____ **Zip:** _____
- **Other's vehicle Year**:_____ **Make**:_____ **Model**:_____ **Speed During Collision**:_____
- **Other's Auto Ins:** _____ **Policy #:** _____ **Claim #:** _____ **Phone #:**_____
  - **Address:** _____ **City:** _____ **State:** _____ **Zip:** _____

WORKER'S COMPENSATION INJURY – ADDITIONAL INFORMATION

Employer: _____ **Occupation:** _____ **Claim #:** _____
Address: _____ **City:** _____ **State:** _____ **Zip:** _____
Contact Person: _____ **Phone:** _____ **Email:** _____

GENERAL ACCIDENT/INJURY INFORMATION – (*PLEASE USE THE REVERSE SIDE OF THIS PAGE IF ADDITIONAL SPACE IS NEEDED*)

Date of Accident: ____/____/_____ **Time**: ___:_____ AM / PM **State Accident Occurred In**:_____
Please describe the accident in as much detail as possible? _____
_____
_____
_____

Before the accident/injury:

- **Have you ever had any complaints in the involved area before? · No · Yes**
  - *If yes* - **Were they present at the time of the accident/injury? · No · Yes**
    - *If yes* - **Summarize these complaints prior to the accident:** _____
- **Were you capable of performing all of your work activities without restriction? · No · Yes**

At the time of the accident/injury:

- **Did you feel pain immediately after the accident? · No · Yes · Later that day · Next day · When?** _____
- **Were you taken anywhere after the accident? · No · Yes · Later that day · Next day · When?** _____
  - *If yes,* **How?**_____ **Where?**_____
  - *If yes,* **Did you receive treatment? · No · Yes -** *(Describe)*_____

Since the accident/injury:

- **Are your symptoms: · Improving? · Getting Worse? · The Same?**
- **Are your work activities restricted as a result of this accident/injury? · No · Yes -** *(How?)* _____
- **Have you missed any work since this accident? · No · Yes -** *(Dates?)* _____
- **Have you retained an Attorney? · No · Yes - Name:**_____ **Phone:** _____
  - **Address:** _____ **City:** _____ **State:** _____ **Zip:** _____

Patient No: _____