

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) _____
- Were you knocked unconscious? No Yes (How long?) _____
- Where was your vehicle impacted? Front / Rear / Passenger Side / Driver's Side / Other: _____
- Where was the other vehicle impacted? Front / Rear / Passenger Side / Driver's Side / Other: _____
- Your Auto Ins: _____ Policy #: _____ Claim #: _____ Phone #: _____
 - Address: _____ City: _____ State: _____ Zip: _____
- 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

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: _____