

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: _____