

MOTOR VEHICLE COLLISION/PERSONAL INJURY QUESTIONNAIRE

Please answer all questions completely:

1. Your name and address:

2. Phone Number: _____

3. Please describe the collision in your own words:

4. Where did the collision occur? City/Town: _____ State: _____

5. Date of collision: _____ Time: _____ AM PM

6. Were you the: driver passenger pedestrian

7. If passenger, were you in the front seat right rear seat left rear seat

8. What type of vehicle were you in? _____

9. What type was the other vehicle? _____

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 the rear the left side the right side

15. What was the approximate speed at the time of the impact?

Your vehicle _____ mph Other vehicle _____ mph

16. What was the weather at the time of the collision? dry wet icy

17. Was your vehicle in: park neutral in gear moving stopped

18. Were your brakes being applied? yes no

19. Was your vehicle shoved: forward backward sideways

20. Were you shoved: forward whipped backward

21. Did your seat have a head restraint (headrest?) yes no

22. If yes, what was the position low midposition high
23. Did your head ride over the headrest? yes no
24. Did your hat/glasses end up in the back seat or rear window? yes no
25. Did any other part of your body hit the interior of the vehicle? yes no
26. If yes, please specify: seatbelt restraints steering wheel dashboard
 windshield side door side window other _____
27. Which part of your body? chest head chin face R L knee
 R L shoulder R L hand other _____
28. Were you holding on to the steering wheel? yes no
29. Did you brace your arms against the dash? yes no
30. Did you brace your legs against the floorboard? yes no
31. Was your ankle turned? yes no
32. Did the vehicle go into a spin or roll as a result of the impact? yes no
33. If yes, explain: _____
34. How much damage was there to the outside of the vehicle? none some a lot
35. How much damage was there to the inside of the vehicle? none some a lot
36. At the point of impact, where did you experience pain? Be specific:

37. Immediately after the accident were you: conscious dazed unconscious
38. If you lost consciousness, how long? _____
39. Were you wearing a seat belt? yes no
40. Did the belt have a shoulder harness? yes no
41. If yes, did it contribute to the pain you are experiencing? yes no
42. At the time of impact were you: looking straight ahead looking to the right
 looking to the left looking down looking up
43. Did the seat break as a result of the impact? yes no
44. Were you braced for the impact? yes no
45. Were you surprised by the impact? yes no
46. Did you go to the hospital? yes no
47. If yes, when? right after the accident next day other _____

48. If yes, how did you get there? ambulance other: _____

49. If by ambulance, did the ambulance attendants place you in a: neck brace
 back brace other _____

50. Any medication or medical supplies given? _____

51. Did you have x-rays taken at the hospital? yes no

If you went to the hospital, please answer the following:

Name of hospital _____

Name of doctor _____

Diagnosis _____

Treatment Received _____

52. Have you had any similar problems before? yes no

53. If yes, explain: _____

54. Are you diabetic? yes no

55. Do you have high blood pressure? yes no

56. Do you have low blood pressure? yes no

57. Do you have arthritis or degenerative joint disease? yes no

58. What type of work do you do? _____

59. What are your job requirements? _____

60. Have you lost any days of work from this injury? yes no

61. If yes, give dates: _____

Patient Signature _____ Date _____

Witness _____ Date _____

Print Name _____

PERSONAL INJURY INSURANCE COVERAGE

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 _____

Will company accept assignment of benefits? yes no

If not, will they make checks payable to patient and our office? yes no

Limits: How much? \$ _____ What's left? _____

GROUP HEALTH INSURANCE

Medical benefits under auto insurance? yes no

Insurance Company _____

Address _____

Phone Number _____

Insured Name _____

Agent _____ Policy# _____ Phone _____

Name and address of other party or parties involved in collision:

ATTORNEY INFORMATION

Date _____ Spoke With _____ Number _____

Patient Name _____

Attorney Name _____

Address _____

Phone Number _____

Does attorney need copies of bills? yes no

In the event of settlement, will they protect any unpaid balance? yes no

Do they have PIP? yes no Do we file? yes no

Do they have insurance? yes no Do we file? yes no

Can we file liability? yes no