AUTOMOBILE INJURY QUESTIONNAIRE

Name: _____ Date of Accident: _____ Time of Accident: _____

Location of Accident: _____ On Public Road __ Yes __ No On Private Property ___Yes ___No

Did police come to accident ___ Yes ___ No Which police department? _____

Who receive a citation for the accident? ___ Other Driver ___You ____ No One

Liability for accident: ___Another's Fault ___ My Fault Were you the: ___ Driver ___ Passenger ___ Pedestrian

Was your vehicle struck from the: ___ Front ___ Behind ___ Right Side ___ Left Side ___ Head-On

How much damage was done to your car: $_____ How much to the other vehicle: $_____

Year _____ Make _____ Model _____ Color _____ of your vehicle

At the time of collision, was your vehicle: ____ Stopped ____ Moving

At the time of impact, were you thrown: ____ Not Thrown ___ Forward ___ Backward ___ Right ___ Left

At the time of impact, did you strike the: ____ Other: _____ ____ Rear View Mirror

___ Left Side Door ___ Steering Wheel ___ Console ___ Right Side Door ___ Ceiling ___ Windshield

___ Left Window ___ Dashboard ___ Gear Shift ___ Right Window ___ Front Seat ___ Arm Rest

What body part struck the item listed in the preceding question?

___ Head ___ Left Arm ___ Right arm ___ Left Leg ___ Right Leg ___ Torso

Did you know you were about to have an accident? ___ Yes ___ No

What kind of restraints were you wearing? ___ No Belt ___ Lap & Shoulder Belt ___ Lap Belt Only ___ Shoulder Belt Only

What position was your headrest in at the time of collision? ___ No Headrest ___ Low ___ Middle ___ High ___ Don't Know

Did the airbags deploy? ___ Yes ___ No ___ Vehicle does not have airbags

After the accident, you were taken to: ____ Hospital ____ Emergency Clinic ____ Your regular doctor

____ Did not required medical attention at the time of the accident

Were you rendered unconscious? ___ Yes ___ No

When did you symptoms relating to the accident first occur?

___ Immediately ___ Within a few hours ___ Next Day ___ Within 1 week ___ Other: _____

Were other people in your vehicle at the time of the accident? ____ Yes ____ No

If Yes, Name and Phones: _____

List the extent of the injuries as you know them: _____

_____ Was the driver of the other car injured: __ Yes __ No

Please give the name and phone number and dates of all doctors you have seen in the past for this injury:

_____

List all dates lost from work _____ Employer _____

Name of your *AUTO* insurance company _____ Phone# _____ Policy # _____

Auto Insurance coverage amount: Liability _____ PIP _____ Medical _____

Name of Insurance Company of the person in the other vehicle: _____ Phone # _____

Name of your major medical/group health insurance company _____ Phone # _____ Policy # _____

Year and dates that you have filed claims for auto accident injuries prior to this one _____

Have you been contacted by any insurance adjuster or company representative regarding this claim? ____ Yes ____ No

Name and phone number of adjuster: _____

Name of the attorney that has advised you in this case: _____

Address: _____ State ____ Zip _____ Phone # _____

Signature_____ Date _____