

# 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 / 2<sup>nd</sup> Row / 3<sup>rd</sup> 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: \_\_\_\_\_