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Automobile Collision Questionnaire

Name: ______________________________ Today's Date: _____________ Date of accident: __________

PLEASE WRITE A DESCRIPTION OF THE ACCIDENT:

____

____

____

____

If auto accident, were you: [ ] driver [ ] passenger [ ] pedestrian

Location: City ________________ State _______Street(s) _____________________________

Road Conditions: [Dry] [Wet] [Icy] Other:__________________________

What kind of vehicle were you in:____

What type of transmission in your vehicle: [ ] Automatic [ ] Manual (stick-shift)

Were you aware of the impending collision or were you surprised? [ ] Aware [ ] Surprised

If auto collision, were you struck from: [ ] behind [ ] right side [ ] left side [ ] front

Did the other car strike yours? [ ] yes [ ] no Did your car strike the others involved? [ ] yes [ ] no

Were there multiple impacts: [ ] yes [ ] no If yes, how many__________________________

Was your foot on the brake? [ ] yes [ ] no were you wearing your seatbelt? [ ] yes [ ] no

Did any Airbags deploy? [ ] yes [ ] no [ ] front [ ] side curtain

At the impact was your head facing: [ ] forward [ ] to the right [ ] to the left [ ] Other:__________

How was the headrest positioned for your head? [ ] high [ ] low [ ] middle [ ] no head rest

After the collision, what direction was your vehicle facing: [ ] Same [ ] to the right [ ] to the left

[ ] facing the opposite direction [ ] not sure [ ] Other:_____________________________

What was the other vehicle?____

Were there more than one other vehicle involved: [ ] yes [ ] no how many?_____________________

What kind:____

Did the impact cause you to lose your glasses or hat? [ ] yes [ ] no

Did you hit any part of the body on anything inside the vehicle? [ ] no [ ] yes, what?______________

Did you lose consciousness? [ ] yes [ ] no Were you treated by the Paramedics at the scene? [ ] yes [ ] no

Were you taken by ambulance to the hospital emergency room? [ ] yes [ ] no

Did you have x-rays taken? [ ] yes [ ] no what regions?______________________________________

Were you given any medications? [ ] yes [ ] no what?____

Condition Since Accident: [Worsened] [Improved] [Stayed the same]

PLEASE CHECK SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT:

[ ] Headaches	[ ] Dizziness	[ ] Light Bothers Eyes	[ ] Diarrhea
[ ] Neck Pain	[ ] Head Seems Too Heavy	[ ] Loss of Memory	[ ] Constipation
[ ] Neck Stiffness	[ ] Pins and Needles in Arms	[ ] Ears Ringing	[ ] Stomach Upset
[ ] Upper Back Pain	[ ] Pins and Needles in Legs	[ ] Face Flushed	[ ] Hands Cold
[ ] Middle Back Pain	[ ] Numbness in Fingers	[ ] Buzzing in Ears	[ ] Feet Cold
[ ] Lower Back Pain	[ ] Numbness in Toes	[ ] Loss of Balance	[ ] Cold Sweats
[ ] Anxiety	[ ] Shortness of Breath	[ ] Loss of Smell	[ ] Fever
[ ] Irritability	[ ] Fatigue	[ ] Loss of Taste	[ ] ______________
[ ] Chest Pain	[ ] Depression	[ ] Sleeping Problems	[ ] ______________

Patient's Auto Insurance: Do you have Personal Injury Protection (PIP) [ ] Yes [ ] No

Company Name: __________________________ Address: ____________________________________

Phone #: _________________________________ ____________________________________

Claim #:___________________________ Claim Manager's name: ____________________________

Auto Insurance Company Responsible in Accident:

Company Name: __________________________ Address: ____________________________________

Phone #: _________________________________ ____________________________________

Name of person responsible for accident:____

Name of insured on this policy:____

Claim # :____________________ Claim Manager's name: ______________________________

General Heath Insurance

Ins Co:______________________ Subscriber:______________ ID/Group #:____________________

Do you have an attorney involved in this case? [ ] Yes [ ] No

If so, attorney's name: ____________________________ Phone #:______________________________

I hereby understand that interest will be charged on any unpaid balance due on my account commencing on the first day of my being released from active/scheduled treatment. Interest on my account shall be at the rate of twelve percent (12%) per annum on the balance owed by me and will be calculated half-yearly from date of my release from active/scheduled treatment and every six (6) months thereafter.

Patient's Signature: ____

Parent/Guardian's Signature: ____ **Date:**______________