AUTO INJURY QUESTIONNAIRE FORM

Name: _____ **Name on Policy** (if other than yourself) _____

Home Phone: _____ **Cell Phone**: _____

Your Auto Ins Company_____

ATTORNEY INFORMATION

Name _____ **Phone #** _____ **Ext**: _____

Address _____ **City** _____ **State** _____ **Zip Code**_____

DETAILS OF ACCIDENT

1. **Date of Accident** _____**Time of Day**_____
2. **Were you the:** -----
3. **Does your car have a head rest?** -----
    a. **If yes, what setting was it at time of accident?** -----
4. **Number of People In Vehicle:** _____ **Were you wearing seat belts?** -----
5. **Were you struck from:** -----
6. **Speed of your car?** _____MPH **Other Car?** _____ MPH
7. **Were you knocked unconscious?** -----
    a. **If yes, how long?** _____
7. **Were the Police Notified?** -----
9. **Kind of car you were driving:** Model _____ Make _____ Year _____
10. **How much damage to your car?** $_____ or / Totaled? ☐
11. **In your own words, please describe the accident:**

    _____

    _____

12. **Did you have any physical complaints <u>BEFORE THE ACCIDENT</u>?**
    a. If yes, please describe:

    _____

13. **Please describe how you felt:**
    a. During the accident _____
    b. Immediately after the accident: _____
    c. Later that Day: _____
    d. The next Day: _____
14. **Where were you taken after the accident?**_____
15. **What type of treatment did you receive?** _____

16. **What other Doctors have treated you since the accident, if any?**
17. **Since the accident, your symptoms are:** -----
18. **Have you lost time from work as a result of this accident?** -----
19. **Have you noticed any activity restrictions as a result of this accident?** -----
    a. If yes, please explain: _____