# AUTO ACCIDENT QUESTIONNAIRE

**Patient's Name:**_____ **Date:** _____

**Date of the accident:** _____ **Time:** _____ **AM PM**

**Location where accident occurred:** _____

**Your position in the vehicle:** ☐ Driver ☐ Front passenger ☐ Rear passenger (center) ☐ Rear passenger (left) ☐ Rear passenger (right)

**Describe how the accident happened:** _____

_____

_____

_____

**How fast was your vehicle traveling at the time of impact?** _____

**If another vehicle was involved, how fast was it traveling at the time of impact?** _____

**The impact to your vehicle was from:** ☐ the front ☐ the rear ☐ the left side ☐ the right side

**Were you wearing a seat belt?** _____ **How many people were in your vehicle?** _____

**At the time of impact, what direction were you looking?** ☐ front ☐ rear ☐ left ☐ right ☐ unknown

**Did the impact cause you to strike your body on any part of the vehicle or on anything inside the vehicle?** _____ **If YES, please describe:** _____

_____

**Were you transported to a hospital?** _____ **If YES, which hospital?** _____

**How did you get to the hospital?** ☐ ambulance ☐ I drove myself ☐ someone else drove me

**When did you go to the hospital?** _____

**What did they do at the hospital?** _____

**Have you been treated by any other healthcare providers for the injuries you received in this accident?** _____ **If YES, please describe:** _____

_____

**What symptoms did you feel <u>immediately following</u> this accident?** _____

_____

_____

_____

**What symptoms are you feeling <u>at the present time</u>?** _____

_____

_____

_____

**Name of your automobile insurance carrier:** _____

**Phone number of your automobile insurance carrier:** _____

**Policy Number:** _____ **Claim Number:** _____

**Patient's (or legal guardian's) Signature:** _____ **Date:** _____