

AUTOMOBILE ACCIDENT QUESTIONNAIRE

Name _____ Date _____

Date of accident: _____

Type of vehicle you were in: _____

Other vehicle type: _____

Were you the driver? _____

If you were the passenger, where were you sitting? _____

Were you wearing a seatbelt? _____ Were you wearing a lap belt? _____

Did your vehicle have an airbag? _____ If so, did it deploy? _____

What were the road conditions? (wet, dry, icy, gravel, pavement) _____

Type of impact? (side, front, rear-end) _____

Was your vehicle stopped or moving at the moment of impact? _____

How much damage was sustained by the vehicles in the accident? _____

Was your vehicle drivable after the accident? _____

Were you aware the accident was going to happen? _____

Did you brace yourself? _____

How many vehicles in the collision? _____

Were you knocked unconscious? _____

How did you feel immediately following the collision? _____

How did you feel hours or days later? _____

Did you go to the emergency room? _____ If so, what was done at the ER? _____

Have you had any treatments before coming to my office today? _____ If so, what? _____

How did you respond to this treatment? _____

Have you lost time from work due to this accident? _____

Did this accident occur in the course of your work? _____

Have you had an automobile accident in the past? _____ If so, what areas of the body were injured? _____

What symptoms were you having before this collision? _____

Have you retained an attorney? _____ If so, name and address _____

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