Auto Accident Injury Questionaire

Name: ______________________________ Cell Phone: __________________________
Address: ______________________________ Home Phone: _________________________
City, State, Zip: ______________________________ Work Phone: __________________________

Insurance Information

(Your) Insurance Company: ____
Phone: ____
Claim Number: ____
Agent: ____
Insured Name: ____

(Other Driver) Insurance Company: ____
Phone: ____
Claim Number: ____
Agent: ____
Insured Name: ____

Accident Information

Date of Accident: ____________________ Time of Day: _______________________
Police Notified: YES: _____ NO: _____
Ticket Issued: YES: _____ NO: _____ Ticket Issued to Whom: ________________
Taken to Hospital: YES: _____ NO: _____ Hospital Name: _______________________
Lost Time from Work: YES: _____ NO: _____ Date: ______________________________

Nature of Accident

Name of City: ____________________ Address __________________________
Patient Status: Driver: _____ Passenger: _____ Front Seat: _____ Back Seat: ____
Direction Headed: North: _____ South: _____ East: _____ West: ____
Struck From: Rear: _____ Front: _____ Left Side: _____ Right Side: ____
Status of Your Car: Moving: _____ Stopped: _____
Saw Accident Coming: Yes: _____ No: _____
Your Eyes Looking: Ahead: _____ Left: _____ Right: _____ DOWN: ____

Symptoms of Accident

Headaches: ______ Arm Pain: ______ Chest Pain: _____ Hip Pain _____
Dizziness: ______ Mid Back Pain: ______ Rib Pain: _____ Leg Pain _____
Neck Pain: ______ Shoulder Pain: ______ Low Back Pain _____ Sore Muscles _____

Describe Pain ____

____

Describe Accident

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Signature ______________________________________ Date____________