

Automobile Accident Questionnaire

Please answer all questions completely

Name _____ Date of Birth _____

Occupation _____ Date of accident _____

Please explain in detail how your accident happened _____

Insurance Co. _____ Policy # _____

Name of your insurance adjuster _____ Phone # _____

Have you retained an attorney? Y N Name and phone # _____

Driver of other vehicle (if any):

Name _____ Ins. Co. _____ Policy # _____

Driver of vehicle in which you were injured (if applicable)

Name _____ Ins. Co. _____ Policy # _____

You were heading North East South West on _____ (street/ave)

Other vehicle was heading North East South West on _____ (street/ave)

Were police notified? Y N Were you knocked unconscious Y N

You were struck from Behind Front Left side Right side

You were driving passenger using seat belts

Where did you feel pain immediately after the accident? _____

Where were you taken after the accident? _____

What treatment was given? _____

Have you ever had complaints in the involved area before? Y N

Are your work activities restricted as a result of the accident? Y N

Since this injury are your symptoms Improving? Getting worse? Same?

Signature _____ Date _____