550 30th Ave, Suite 12 Moline, IL 61265
Ph (309) 762-5513 F (309) 762-5519

Auto Accident History Questionnaire

Today's Date: ______________ Date of Accident: ________________ State of Accident: ___________

Name: ____ Date of birth: ______________________

Address: ______________________________ City: _________________ State: ______ Zip:________

Phone: ___________________ Cell: ____________________ Work: _____________________

Email: ____

Sex: Male Female **Marital Status**: Married Single **Height**: **Weight**:

Insurance Information

Name of **YOUR PERSONAL VEHICLE** Insurance company:
Company: ______________________________
Address: ____________________________________
Phone: ____________ Adjuster: _________________
Claim #: __________ Policy #: __________________
Driver of car: ________________________________
Year/Model of car: ____________________________

Other Vehicle Insurance Information:
Company: ___________________________
Address: ____________________________
Phone: __________ Adjuster: ___________
Claim #: ________ Policy#: ____________
Driver's name: ________________________
Year/Model of car: _____________________

Approx damage to your car: $____

Was anyone ticketed? (circle one) Yes or No You or other driver

Have you retained an Attorney? Yes or No

Name of Attorney: ____________________________ Phone#: ___________________

Name of YOUR HEALTH MEDICAL Insurance company:
Company: ____ID: ________________________

Address: ____ Phone: ______________________

Policy Subscriber Name: _____________________________ Date of birth: _________________

Please describe the accident:

____

____

____

____

____

Auto Accident History Questionnaire

(Page 2)

General Information

1. Did you seek immediate attention?
   - Yes
   - No (If no, skip to question 4)
2. How did you get there?
   - Ambulance
   - Police
   - Someone else drove me
   - Drove myself
3. Doctor/Facility Name: ____
   - Examined
   - X-rays
   - MRI
   - CT Scan
   - Surgery

   What treatment did you receive?
   - Brace/Collar
   - Stitches
   - Medications
4. Are you currently under any care for injuries related to this accident from any other providers?
   - Yes (please explain)
   - No

   ____

   ____
5. Visibility at time of accident:
   - Poor
   - Fair
   - Good
   - Other

   ____
6. Road Conditions:
   - Icy
   - Rainy
   - Wet
   - Dry
   - Other

   ____
7. Type of Accident:
   - Head-on
   - Broad side
   - Front Impact
   - Rear Impact
8. Where was your car struck?
   - Front
   - Rear
   - Drivers side
   - Passenger side
9. Does your vehicle have a tow hitch?
   - Yes
   - No
10. Did the seatback break?
    - Yes
    - No
11. What parts of your body hit what parts of the inside of the car:

    ____

    ____
12. Did you see the accident coming?
    - Yes
    - No
13. Did you brace for the impact?
    - Yes
    - No
14. Were you wearing a seat belt?
    - Yes
    - No
15. Did your seatbelt have a shoulder restraint?
    - Yes
    - No

Auto Accident History Questionnaire
(Page 3)

16. Was the position of your headrest even with:
    - ○ Top of head ○ Bottom of head ○ Middle of neck ○ No headrest
17. At the time of the accident was your car:
    Moving? ○ Yes ○ No

    Braking? ○ Yes ○ No
18. If moving, what was your approximate speed? ________mph
19. If moving, what was the approximate speed of the other car? ________mph
20. Head/body position at the time of impact:
    - ○ Head turned left/right ○ Looking behind you ○ Head straight ahead ○ Body straight in sitting position ○ Body rotated left/right
21. As a result of the accident were you:
    - ○ Rendered unconscious ○ In shock ○ Dazed ○ Other
22. Were you wearing a hat or glasses?
    - ○ Yes ○ No
23. Could you move all parts of your body?
    - ○ Yes ○ No

    If no, what parts couldn't you move and why? ______________________________
24. Were you able to get out of the car and walk unaided?
    - ○ Yes ○ No

    If not, why? ____
25. Did you have any cuts that were bleeding?
    - ○ Yes ○ No
26. Did you have any bruises?
    - ○ Yes ○ No
27. Please describe how you felt:
    Immediately following the accident:
    ____
    ____
    The next day:
    ____
    ____

28. Check symptoms apparent since the accident:

○ Headache	○ Neck pain/stiffness	○ Mid back pain	○ Eyes sensitive to light	○ Tension
○ Pain behind eyes	○ Dizziness	○ Fainting	○ Loss of smell	○ Facial pain
○ Loss of taste	○ Numbness in fingers/toes	○ Sleep problems	○ Memory problems	○ Irritability
○ Fatigue	○ Shortness of breath	○ Jaw pain/clicking	○ Depression	○ Constipation
○ Loss of balance	○ Ears ringing/buzzing	○ Anxiety/nervous	○ Lower back pain	○ Diarrhea
○ Loss of Focus/attention	○ Difficulty completing tasks	○ Other _____________		

Auto Accident History Questionnaire
(Page 4)

29. Do you work:
    - ○ Full time
    - ○ Part time
    - ○ Not currently working prior to accident
30. Occupation: ____
31. Employer: ____
32. Have you missed time from work?
    - ○ Yes
    - ○ No
33. Dates you were unable to work: ________________ to ___________________
34. Have you been unable to do housework?
    - ○ Yes
    - ○ No

    If not, dates unable to do housework: _______________ to ________________
35. Do you have any pictures of the event?
    - ○ Yes
    - ○ No

    If so, pictures of what?
    - ○ Car
    - ○ Self
    - ○ Other____________________________

Use the space below to add any additional information.

___

____

____

____

____

____

____

____

____

____

____

____