ADL MEDICAL

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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** Other Vehicle Insurance Information:

Insurance company:

Company: _____ Company: _____

Address: _____ Address: _____

Phone: _____ Adjuster: _____ Phone: _____ Adjuster: _____

Claim #: _____ Policy #: _____ Claim #: _____ Policy#: _____

Driver of car: _____ Driver's name: _____

Year/Model of car: _____ 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

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General Information

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

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

   _____

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

   _____
6. Road Conditions:
   - o Icy
   - o Rainy
   - o Wet
   - o Dry
   - o Other

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

    _____

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

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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 _____		

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29. Do you work:
    - o Full time
    - o Part time
    - o Not currently working prior to accident

30. Occupation: _____
31. Employer: _____
32. Have you missed time from work?
    - o Yes
    - o No

33. Dates you were unable to work: _____ to _____
34. Have you been unable to do housework?
    - o Yes
    - o No

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

    If so, pictures of what?
    - o Car
    - o Self
    - o Other _____

Use the space below to add any additional information.