# AUTOMOBILE INJURY QUESTIONNAIRE

Your Name: _______________________________________ Today's Date: ______/______/20______

Have you had any injury claims in the last 5 years? List
_____________________________________________

**Please make drawing of accident:**
**(If police report not provided)**

Date of collision: __________ Time: _______ AM/PM
Weather? [ ] Dry [ ]Wet [ ] Ice/Snow

Please describe the collision in your own words:
_____________________________________________
_____________________________________________
_____________________________________________
_____________________________________________
_____________________________________________

Accident on-the-job? [ ] Yes [ ] No

Where did the collision occur? Street: ___________________________ City/State: _________________

Did police investigate accident? [ ] Yes (City Police County Sherriff State Highway Patrol) [ ] No

Were you the: [ ] Driver [ ] Passenger (Front Right Rear Mid Rear Left Rear)
If passenger, vehicle driven by: _____________________ Relationship: ____________________

What type of vehicle were you in? _______________________ Other vehicle? ____________________

Was your car struck by the other vehicle? [ ] Yes, How fast _______ MPH [ ] No
Was your vehicle [ ] parked/stopped [ ] slowing [ ] accelerating
Was the impact from the [ ] front [ ] rear [ ] left side [ ] right side
Was your vehicle shoved: [ ] forward [ ] backward [ ] sideways
Did the vehicle go into a spin or roll as result of impact? [ ]Yes [ ] No

Did your vehicle strike other vehicle? [ ]Yes. How fast _______ MPH [ ] No
Was other vehicle [ ] parked/stopped [ ] slowing [ ] accelerating
Other notes: ____________________________________________________________________

Vehicle damage: Estimate your vehicle: $______________ Estimate other vehicle: $_______________
How much damage was there to the outside of the vehicle? [ ] None [ ] Some [ ] A Lot
How much damage was there to the inside of the vehicle? [ ] None [ ] Some [ ] A Lot
Seat back: [ ] Adjustment altered [ ] Broke

Have you lost any days of work from this injury? [ ] Yes, dates________________ [ ] No

# AUTOMOBILE INJURY QUESTIONNAIRE, Cont.

During the accident,

Were you shoved: [ ] forward [ ] whipped backward

Were you surprised by the impact? [ ] Yes [ ] No

Were you wearing a seat belt? [ ] Yes (lap belt, lap/shoulder belt) [ ] No

Air bag deploy? [ ] Yes [ ] No

Did it contribute to the pain you are experiencing? [ ] Yes [ ] No

Did you have a head restraint (headrest)? [ ] Yes [ ] No

If yes, what was the position [ ] low [ ] midposition [ ] high [ ] unsure

Did your head ride over the headrest? [ ] Yes [ ] No

Body position: [ ] Good [ ] Forward lean [ ] ___________________________________________

At the time of impact were you: [ ] looking straight ahead [ ] looking to the right

[ ] looking to the left [ ] looking down [ ] looking up

Did your hat / glasses come off? [ ] Yes, where__________ [ ]No [ ] Not wearing

Where you holding on to the steering wheel? [ ] Yes, ______hand(s) [ ] No

Did you brace your arms against the dash? [ ] Yes [ ] No

Did you brace your legs against the floorboard? [ ] Yes [ ] No

Did any other part of your body hit the interior of the vehicle? [ ] Yes [ ] No

[ ] seatbelt restraints [ ] steering wheel [ ] dashboard [ ] windshield

[ ] side door [ ] side window [ ] other __________________________________

Immediately after the accident were you: [ ] conscious [ ] dazed [ ] unconscious _____min

Other symptoms: [ ] Headache [ ] Dizziness [ ] Nausea [ ] Confusion/disorientation

Pain: [ ] Neck [ ] Shoulder [ ] Elbow [ ] Wrist/Hand [ ] Back [ ] Hip [ ] Knee [ ] Ankle/Foot

[ ] Face/Jaw [ ] Chest [ ] Stomach [ ] Other_____________________________________

Did you go to the hospital or medical facility for injuries sustained from MVA? [ ] Yes [ ] No

If yes, when? [ ] right after the accident [ ] same day [ ] next day [ ] ____ days

How did you get there? [ ] ambulance [ ] self [ ] family / friends [ ] other ________________

If by ambulance, did the EMTs place you in a [ ] neck brace [ ] board [ ] __________________

List medications or supplies given? ________________________________________________

Name of facility? [ ] Cape Fear [ ] Womack [ ] ________________________________________

Name of doctor? ______________________________________________________________

Did you have x-rays taken? [ ] No [ ] Yes. views: ________________________________________

Did you have other test taken? [ ] No [ ] Yes,__________________________________________

Diagnosis: __________________________________________________________________

Treatment Received: ____________________________________________________________

Referral given: ________________________________________________________________

Other medical treatments:_________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

# INSURANCE

**THIRD PARTY PAYER / LIABILITY INSURANCE (OTHER/AT FAULT VEHICLE INSURANCE)**

Third Party (Person at Fault's Name): ________________________________ Phone: _________________

Insurance Carrier: ________________________________ Policy Number: ___________________________

Claim Adjuster Name: ____________________________________ Phone: __________________________

Has an injury claim been opened: [ ] No [ ] Yes Claim Number: _________________________________

Address to mail claim: ____________________________________________________________________

___________________________________________________ Fax: _________________________________

**YOUR AUTOMOBILE INSURANCE POLICY**

"Medical Payments" coverage on your policy? [ ] No [ ] Unsure [ ] Yes, Limits: $_________________

Owner Name: ___________________________________________________ Phone: _________________

Insurance Carrier: ________________________________ Policy Number: ___________________________

Claim Adjuster Name: ____________________________________ Phone: __________________________

Has an injury claim been opened: [ ] No [ ] Yes Claim Number: _________________________________

Address to mail claim: ____________________________________________________________________

___________________________________________________ Fax: _________________________________

**ATTORNEY INFORMATION**

Attorney: _________________________________ Legal Assistant: ________________________________

Office Name: ___________________________________________________________________________

Phone: ______________________________________ Fax: ______________________________________

Address: _______________________________________________________________________________

**CLINIC USE ONLY**

**[ ] POLICE REPORT RECEIVED ___/___/____**

| | | | |
|---|---|---|---|
| **MED PAY** | **[ ] Faxed Initial ___/___/____** | | **[ ] Mailed Final ___/___/____** |
| **LIABILITY** | **[ ] Faxed Initial ___/___/____** | | **[ ] Mailed Final ___/___/____** |
| **ATTORNEY** | **[ ] Faxed Initial ___/___/____** | | **[ ] Mailed Final ___/___/____** |