Auto Accident Questionnaire

Name: _____ Date of accident: _____ Location:_____

Vehicle information: Make:_____ Model:_____ Year:_____

Name of Insurance Carrier: _____Claim Number :_____

Name of Adjuster and Phone Number:_____

Your Location in the Vehicle: Driver Front Passenger Rear Passenger R or L Other

Passengers: Front Passenger Rear Passenger R or L

Accident Description: *Describe in your own words what happened.*

_____

_____

_____

_____

_____

What direction were you traveling in? _____

Other Vehicles Involved in the Accident:

No other vehicles involved.

1st Vehicle to strike you: Car Van Truck Station Wagon Bus Other: _____

Where did the vehicle strike your vehicle?

Head On Sideswiped R or L From Right From Left Rear End Other: _____

What damage did this vehicle sustain?

Minimal Moderate Extensive Totaled Unsure Other: _____

2nd Vehicle to strike you: Car Van Truck Station Wagon Bus Other: _____

Where did the vehicle strike your vehicle?

Head On Sideswiped R or L From Right From Left Rear End Other: _____

What damage did this vehicle sustain?

Minimal Moderate Extensive Totaled Unsure Other: _____

Injuries:

Did you sustain any injuries that required medical attention? Yes No

If so, briefly describe injury and treatment:_____

At the Moment of Impact:

Were you prepared for the accident? Accident was a complete surprise. Aware of the impending collision

Was your foot on the brake pedal? Yes No

If so, was it knocked off at impact? Yes No

Were you wearing a seatbelt? Yes No

Did the airbags deploy? Yes No

Impact to Your Body:

What was your body position at impact?

Straight Slouched Rotated: Right Left Unsure Other:

What direction was your body thrown?

Forward then back Back then forward Right Left Unsure Other:

What was the position of your head/neck at impact?

Straight Tilted Forward Rotated: Right Left Unsure Other:

What direction was your head/neck thrown?

Forward then back Back then forward Right Left Unsure Other:

Did you suffer any head injuries? Yes No

Concussion? Yes No

Did you lose consciousness? Yes No

Did Police arrive at the scene? Yes No

Was an accident report completed? Yes No

Did EMS arrive at the scene? Yes No

Were you transported to the hospital? Yes No

How were you transported? Ambulance Arranged Ride N/A

Was the vehicle towed from the scene? Yes No

Result of Impact:

Did the force of the collision cause your body to strike any object in the vehicle? Yes No

If so, what part of your body hit and what did it strike?

_____

Any other information you would like to provide regarding the accident?

_____

_____

_____

Patient Information *I certify that the information I have provided on this form is true and correct to the best of my knowledge.*

(Print Name) _____

(Sign Name) _____ Date: _____