



Auto Injury Questionnaire

Date of Accident: _____

Brief description of Accident (i.e. rear-ended, head on, side impact, etc.): _____

Describe any secondary collision (i.e. pushed into vehicle in front of you): _____

Do you recall striking anything inside the vehicle? (i.e. knees on dashboard, head on windshield):

Yes No If yes, please describe: _____

Did you lose consciousness? Yes No Were you taken to the hospital? Yes No

What type of vehicle were you in? _____ Estimated speed: _____

What type of vehicle was the other driver in? _____ Estimated speed: _____

Describe damage to your vehicle: Driveable Not Drivable

Were you: Driver Passenger-Sitting: _____

At the time of accident: Visibility was: Good Poor Time of Day: Daylight Night

Road conditions: Dry Wet Ice/Snow Time of Impact: _____

Were you looking Toward Left Toward Right Straight ahead Up Down

As your foot on the brake? Yes No

Were you: Braced for Impact Unaware of Impeding Collision

Were you wearing a seatbelt: Yes No Did your airbag deploy? Yes No

Was your headrest: Adjusted properly Not adjusted properly Don't recall

Your Auto Policy Insurance Name: _____

Claim #: _____ Adjuster Phone #: _____

Party at Fault's Auto Policy Insurance Name: _____

Claim #: _____ Adjuster Phone #: _____

Adjuster(s) Names: _____

Attorney Name(if applicable): _____ Phone #: _____

Patient Name(Print): _____

Parent/Guardian Name(Print): _____

Patient/Parent/Guardian Signature(X): _____ Date: _____