MOTOR VEHICLE ACCIDENT QUESTIONNAIRE

Name: _____ Date: _____

Date Injured: _____ Time: _____ AM/PM

Describe details of the accident: _____

_____

Have you lost any days of work due to this injury? Y / N Dates: _____

Are you represented by an Attorney? Y / N Name: _____

Address: _____ Phone: _____

You were the: ☐ Driver ☐ Front Passenger ☐ Rear Passenger ☐ Pedestrian

in a: ☐ Car ☐ Truck ☐ Other: _____

that: ☐ Struck the other(s) ☐ Was struck by ☐ Car ☐ Truck ☐ Other: _____

☐ Undetermined

Part of your vehicle hit: ☐ Back ☐ Front ☐ Right side ☐ Left side ☐ Other: _____

Part of their vehicle hit: ☐ Back ☐ Front ☐ Right side ☐ Left side ☐ Other: _____

Your vehicle was: ☐ Stopped for a traffic signal ☐ Stopped to make a turn ☐ Parked ☐ Moving at time of impact (describe above in Details of Accident section) ☐ Other: _____

List any other vehicles or objects involved: _____

You were wearing: ☐ Seatbelt ☐ Shoulder harness ☐ Both ☐ None

Airbag(s) opened: ☐ Driver ☐ Passenger ☐ Side ☐ None

At the time of impact, where were you looking and how were you positioned? _____

_____

Did your body strike any part of the vehicle? Y / N Describe in detail: _____

_____

Your estimated vehicle speed: _____ Their estimated vehicle speed: _____ Any Witnesses? Y / N

Was a traffic citations issued? Y / N ☐ You ☐ Driver of your car ☐ Driver of the other car

Was a police report written? Y / N Which city? _____

Were you rendered unconscious as a result of the collision? Y / N

Were you checked by EMS? Y / N What did they recommend? _____

Were you seen at an E.R.? Y / N ☐ Immediately ☐ Later that day ☐ Other: _____

Which hospital? _____

How did you get there? ☐ EMS ☐ Drive ☐ Taken by friend/spouse

What did they prescribe or recommend? _____

Have you seen any other doctors or had any treatment? Y /N

What did they prescribe or recommend? _____