MOTOR VEHICLE COLLISION/PERSONAL INJURY QUESTIONNAIRE

PI	ease answer all questions completely:			
1.	Your name and address:			
	,			
2.	Phone Number:			
3.	Please describe the collision in your own words:			
4.	Where did the collision occur? City/Town: State:			
5.	Date of collision: Time: AM PM			
6.	Were you the: ☐ driver ☐ passenger ☐ pedestrian			
7.	If passenger, were you in the □ front seat □ right rear seat □ left rear seat			
8.	What type of vehicle were you in?			
9.	What type was the other vehicle?			
10	. Did your vehicle strike the other vehicle? ☐ yes ☐ no			
11	.Was your car struck by the other vehicle? □ yes □ no			
12	.What direction was your vehicle going?			
13	. What direction was the other vehicle going?			
14	. Was the impact from: □ the front □ the rear □ the left side □ the right side			
15	. What was the approximate speed at the time of the impact?			
	Your vehicle mph Other vehicle mph			
16	.What was the weather at the time of the collision? ☐ dry ☐ wet ☐ icy			
17	.Was your vehicle in: □ park □ neutral □ in gear □moving □stopped			
18	.Were your brakes being applied? □ yes □ no			
19	.Was your vehicle shoved: □ forward □ backward □ sideways			
20	.Were you shoved: □ forward □ whipped backward			
21	. Did your seat have a head restraint (headrest?) □ yes □ no			

22. If yes, what was the position □ low □ midposition □ high						
23. Did your head ride over the headrest? ☐ yes ☐ no						
24. Did your hat/glasses end up in the back seat or rear window? ☐ yes ☐ no						
25. Did any other part of your body hit the interior of the vehicle? ☐ yes ☐ no						
26. If yes, please specify: ☐ seatbelt restraints ☐ steering wheel ☐ dashboard						
☐ windshield ☐ side door ☐ side window ☐ other						
27. Which part of your body? ☐ chest ☐ head ☐ chin ☐ face ☐ R L knee						
□ R L shoulder □ R L hand □ other						
28. Were you holding on to the steering wheel? □ yes □ no						
29. Did you brace your arms against the dash? ☐ yes ☐ no 30. Did you brace your legs against the floorboard? ☐ yes ☐ no						
32. Did the vehicle go into a spin or roll as a result of the impact? ☐ yes ☐ no						
33. If yes, explain:						
34. How much damage was there to the outside of the vehicle? \Box none \Box some \Box a lot						
35. How much damage was there to the inside of the vehicle? \square none \square some \square a lot						
36. At the point of impact, where did you experience pain? Be specific:						
37. Immediately after the accident were you: □ conscious □ dazed □ unconscious						
38. If you lost consciousness, how long?						
39. Were you wearing a seat belt? □ yes □ no						
40. Did the belt have a shoulder harness? □ yes □ no						
41. If yes, did it contribute to the pain you are experiencing? ☐ yes ☐ no						
42. At the time of impact were you: □ looking straight ahead □ looking to the right						
☐ looking to the left ☐ looking down ☐looking up						
43. Did the seat break as a result of the impact? ☐ yes ☐ no						
44. Were you braced for the impact? □ yes □ no						
45. Were you surprised by the impact? □ yes □ no						
46. Did you go to the hospital? ☐ yes ☐ no						
47. If yes, when? □ right after the accident □ next day □ other						

48. If yes, how did you get there? □ ambulance other:					
49. If by ambulance, did the ambulance attendants place you in a: □ neck brace					
□ back brace □ other					
50. Any medication or medical supplies given?					
51. Did you have x-rays taken at the hospital? □ yes □ no					
If you went to the hospital, please answer the following:					
Name of hospital					
Name of doctor					
Diagnosis					
Treatment Received					
52. Have you had any similar problems before? □ yes □ no					
53. If yes, explain:					
54. Are you diabetic? ☐ yes ☐ no					
55. Do you have high blood pressure? ☐ yes ☐ no					
56. Do you have low blood pressure? ☐ yes ☐ no					
57. Do you have arthritis or degenerative joint disease? ☐ yes ☐ no					
58. What type of work do you do?					
59. What are your job requirements?					
60. Have you lost any days of work from this injury? ☐ yes ☐ no					
61. If yes, give dates:					
Datient Cinnature					
Patient Signature Date					
Witness Date					
Print Name					

PERSONAL INJURY INSURANCE COVERAGE

Date	Spoke With	Number						
Patient Name								
	any							
Insured Name								
Date of Accident								
Claim Number								
Policy Number								
Has the accident been reported? □ yes □ no								
Name of adjuster handling claim								
Will company accept assignment of benefits? ☐ yes ☐ no								
If not, will they ma	ake checks payable to patient and o	our office? □ yes □ no						
Limits: How much	n? \$ What's left	?						
	GROUP HEALTH INS	SURANCE						
Medical benefits under auto insurance? □ yes □ no								
Insurance Company								
Insured Name								
Agent	Policy#	Phone						
Name and address of other party or parties involved in collision:								

ATTORNEY INFORMATION

Date	Spoke With	P	Number
Patient Name			
Attorney Name			
Address			
Phone Number			
Does attorney need co	pies of bills? □ yes	□ no	
In the event of settleme	ent, will they protect a	ny unpaid balance? [⊐ yes □ no
Do they have PIP? □ y	/es □ no	Do we file? ☐ yes	□ no
Do they have insurance	e? □ yes □ no	Do we file? ☐ yes	□ no
Can we file liability? □	ves □ no		