

MOTOR VEHICLE COLLISION/PERSONAL INJURY QUESTIONNAIRE Page 1

Please answer all questions completely:

1. Your name: _____ Phone Number: _____
2. Please describe the collision in your own words: _____

3. Where did the collision occur? City/Town: _____ State: _____
4. Date of collision: _____ Time: _____ AM PM
5. Were you the: driver passenger pedestrian
6. If passenger, were you in the front seat right rear seat left rear seat
7. What type of vehicle were you in? Make: _____ Model: _____
8. What type was the other vehicle? Make: _____ Model: _____
9. Did your vehicle strike the other vehicle? yes no
10. Was your car struck by the other vehicle? yes no
11. Was the impact from: the front the rear the left side the right side
12. What was the approximate speed at the time of the impact?
Your vehicle _____ mph Other vehicle _____ mph
13. What was the weather at the time of the collision? dry wet icy
14. Was your vehicle in: park neutral in gear moving stopped
15. Were your brakes being applied? yes no
16. Was your vehicle shoved: forward backward sideways
17. Were you shoved: forward whipped backward
18. Did your seat have a head restraint (headrest?) yes no
19. If yes, what was the position low mid position high
20. Did your head ride over the headrest? yes no
21. Did your hat/glasses end up in the back seat or rear window? yes no
22. Did any other part of your body hit the interior of the vehicle? yes no
23. If yes, please specify: seatbelt restraints steering wheel dashboard
 windshield side door side window other _____
24. Which part of your body? chest head chin face R L knee
 R L shoulder R L hand other _____
27. Were you holding on to the steering wheel? yes no
25. Did the vehicle go into a spin or roll as a result of the impact? yes no
26. If yes, explain: _____
27. How much damage was there to the outside of the vehicle? none some a lot
28. How much damage was there to the inside of the vehicle? none some a lot
29. At the point of impact, where did you experience pain? Be specific:

30. Immediately after the accident were you: conscious dazed unconscious
31. If you lost consciousness, how long? _____
32. Were you wearing a seat belt? yes no
33. Did the belt have a shoulder harness? yes no
37. If yes, did it contribute to the pain you are experiencing? yes no
38. At the time of impact were you: looking straight ahead looking to the right
 looking to the left looking down looking up
34. Did the seat break as a result of the impact? yes no
35. Were you braced for the impact? yes no
36. Were you surprised by the impact? yes no
37. Did you go to the hospital? yes no
38. If yes, when? right after the accident next day other _____

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Please answer all questions completely:

44. If yes, how did you get there? ambulance other: _____

45. If by ambulance, did the ambulance attendants place you in a: neck brace
 back brace other _____

46. Any medication or medical supplies given? _____

47. 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 _____

48. Have you had any similar problems before? yes no

49. If yes explain: _____

50. Do you have arthritis or degenerative joint disease? yes no

51. What type of work do you do? _____

52. What are your job requirements? _____

53. Have you lost any days of work from this injury? yes no

54. If yes, give dates: _____

Patient Signature _____ Date _____

Print Name _____

Witness _____ Date _____

PERSONAL INJURY INSURANCE COVERAGE

Insurance Co. _____ Phone# _____

Insured Name _____ Date of Accident _____

Claim Number _____ Policy Number _____

Has the accident been reported? yes no Med Pay Limits: How much? \$ _____

Name of adjuster handling claim: _____

AT FAULTS INSURANCE COMPANY

Insurance Co. _____ Phone# _____

Insured Name _____ Date of Accident _____

Claim Number _____ Policy Number _____

Has the accident been reported? yes no

Name of adjuster handling claim: _____

ATTORNEY

Attorney _____ Phone# _____

Address _____

GROUP HEALTH INSURANCE

Insurance Company _____

Address _____

Phone# _____

Insured Name _____

ID# _____ Group# _____