Auto Accident Questionnaire

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Your Name _____ Today's Date _____

Your Insurance Company _____ Policy # _____

Address where bills are to be sent: Claim # _____

_____

_____

_____

Your claims adjustor _____ Phone # _____

Fax #: _____ Email Address: _____

Make and Model of Car you were in _____ Date of Accident _____

Describe what occurred (a sketch of accident situation is very helpful): Wearing seatbelt? *Yes* *No*

Do you seem to have "blank spots" in your memory of the accident or just afterward? *Yes* *No*

If so, what events are "missing?" _____

_____

Were you unconscious? *Yes* *No* If so, for how long? _____ How do you know this? _____

_____

To the best of your recollection, did your head or other parts of your body hit anything? *Yes* *No*

If so, please describe briefly: _____

_____

_____

Describe how you felt immediately after the accident: _____

_____

_____

Describe how you felt over the next few days, (what was better, worse, and did anything new develop?)

_____

_____

_____

Please mark any of the following symptoms if you have experienced them in the past few days and feel they are related to the auto accident. Mark the "New" box if you have never had that symptom prior to this accident. Mark the "Worse" box if you have had that symptom prior to this accident, but it is worse since. *For "How Intense?" and "How Often?" draw an oval to depict the range from best to worst, and place an "X" where it is most of the time:*

Symptom	**New**	**Worse**	*(None)* **How Intense?** *(Severe)*	*(Never)* **How Often?** *(Constant)*
Headaches	☐	☐	| - - - - - - - - - - |	| - - - - - - - - - - |
Neck Pain	☐	☐	| - - - - - - - - - - |	| - - - - - - - - - - |
Shoulder Pain	☐	☐	| - - - - - - - - - - |	| - - - - - - - - - - |
Arm or Hand Pain	☐	☐	| - - - - - - - - - - |	| - - - - - - - - - - |
Arm/Hand Numbness	☐	☐	| - - - - - - - - - - |	| - - - - - - - - - - |
Arm/Hand Tingling	☐	☐	| - - - - - - - - - - |	| - - - - - - - - - - |
Upper/Mid Back Pain	☐	☐	| - - - - - - - - - - |	| - - - - - - - - - - |
Lower Back Pain	☐	☐	| - - - - - - - - - - |	| - - - - - - - - - - |
Pelvic/Hip Pain	☐	☐	| - - - - - - - - - - |	| - - - - - - - - - - |
Leg/Knee/Foot Pain	☐	☐	| - - - - - - - - - - |	| - - - - - - - - - - |
Leg/Foot Numbness	☐	☐	| - - - - - - - - - - |	| - - - - - - - - - - |
Leg/Foot Tingling	☐	☐	| - - - - - - - - - - |	| - - - - - - - - - - |
Digestive Disturbance	☐	☐	| - - - - - - - - - - |	| - - - - - - - - - - |
Fatigue	☐	☐	| - - - - - - - - - - |	| - - - - - - - - - - |
Dizziness	☐	☐	| - - - - - - - - - - |	| - - - - - - - - - - |
Vision Change	☐	☐	| - - - - - - - - - - |	| - - - - - - - - - - |
Trouble Concentrating	☐	☐	| - - - - - - - - - - |	| - - - - - - - - - - |
Bothered by Noise	☐	☐	| - - - - - - - - - - |	| - - - - - - - - - - |
Bothered by Light	☐	☐	| - - - - - - - - - - |	| - - - - - - - - - - |
Short Temper	☐	☐	| - - - - - - - - - - |	| - - - - - - - - - - |
Forgetful	☐	☐	| - - - - - - - - - - |	| - - - - - - - - - - |
Nervous in Groups	☐	☐	| - - - - - - - - - - |	| - - - - - - - - - - |
Anxious in General	☐	☐	| - - - - - - - - - - |	| - - - - - - - - - - |
Wide Mood Swings	☐	☐	| - - - - - - - - - - |	| - - - - - - - - - - |
Trouble Sleeping	☐	☐	| - - - - - - - - - - |	| - - - - - - - - - - |
Sleep too Much	☐	☐	| - - - - - - - - - - |	| - - - - - - - - - - |
Ringing in Ears	☐	☐	| - - - - - - - - - - |	| - - - - - - - - - - |
Trouble w/any of the following:				
Memory	☐	☐	| - - - - - - - - - - |	| - - - - - - - - - - |
Hearing	☐	☐	| - - - - - - - - - - |	| - - - - - - - - - - |
Speaking	☐	☐	| - - - - - - - - - - |	| - - - - - - - - - - |
Reading	☐	☐	| - - - - - - - - - - |	| - - - - - - - - - - |
Writing	☐	☐	| - - - - - - - - - - |	| - - - - - - - - - - |
Spelling	☐	☐	| - - - - - - - - - - |	| - - - - - - - - - - |
Making Decisions	☐	☐	| - - - - - - - - - - |	| - - - - - - - - - - |
Planning	☐	☐	| - - - - - - - - - - |	| - - - - - - - - - - |
Organizing	☐	☐	| - - - - - - - - - - |	| - - - - - - - - - - |
Following Directions	☐	☐	| - - - - - - - - - - |	| - - - - - - - - - - |
Get lost while Driving	☐	☐	| - - - - - - - - - - |	| - - - - - - - - - - |