

Downtown Chiropractic  
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## AUTOMOBILE ACCIDENT QUESTIONNAIRE (PLEASE PRINT)

Name: \_\_\_\_\_ Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

### ACCIDENT DETAILS:

Date of Accident: \_\_\_\_/\_\_\_\_/\_\_\_\_ Time of Day: \_\_\_\_\_ AM PM Location of Accident \_\_\_\_\_

City or town in which accident took place: \_\_\_\_\_ State: \_\_\_\_\_

Were you a  Driver  Passenger  Pedestrian Name of Driver (if not you): \_\_\_\_\_

Were you struck from  Behind  Right Side  Left Side  Front

Were you looking straight ahead, to the left, or to the right?  Straight Ahead  To the Left  To the Right

Was your vehicle  stopped to make a turn  stopped for a traffic signal  parked  moving at the time of impact

Other: \_\_\_\_\_

Did your body strike anything in the car?  YES  NO Describe in detail: \_\_\_\_\_

Were you wearing a seat belt?  YES  NO

Describe in detail how the accident occurred: \_\_\_\_\_

Were you rendered unconscious as a result of the collision?  YES  NO

Were you taken to the hospital after the accident?  YES  NO By ambulance or private car? \_\_\_\_\_

Were you taken to the hospital *immediately* after the accident?  YES  NO

If not, how much time had elapsed before you went to the hospital? \_\_\_\_\_

Which hospital were you taken to? \_\_\_\_\_

Have you been x-rayed since the accident?  YES  NO If so, where? \_\_\_\_\_

Have you received an MRI since the accident?  YES  NO If so, where? \_\_\_\_\_

Have you lost any days of work as a result of the accident?  YES  NO If yes, how many days have you lost? \_\_\_\_\_

Have you ever been in a previous auto accident? Describe all instances, giving approximate dates of the accidents, as well as the injuries sustained, and names of attorneys who represented you.

Date of Accident: \_\_\_\_/\_\_\_\_/\_\_\_\_ Injuries sustained \_\_\_\_\_

Name of Attorney in That Case: \_\_\_\_\_

Approximate Year / Date When Case Settled or Was Resolved: \_\_\_\_\_

Date of Accident: \_\_\_\_/\_\_\_\_/\_\_\_\_ Injuries sustained: \_\_\_\_\_

Name of Attorney in That Case: \_\_\_\_\_

Approximate Year / Date When Case Settled or Was Resolved: \_\_\_\_\_

Did a police officer write up a police report on the accident?  YES  NO

Do you have a copy of the police report?  YES  NO (if yes, please provide our office with a copy of this report)

Was a ticket or citation issued by a police officer as a result of the accident?  YES  NO

Who received the ticket or citation? \_\_\_\_\_

Do you have any information, including insurance information, concerning the other parties involved in the accident?

YES  NO (If yes, please provide our office with a copy of this information)

Did the accident involve a hit-and-run driver?  YES  NO

Are you, yourself, licensed to drive?  YES  NO (please provide our office with a copy of your license)

Was the car in which you were at the time of the accident registered?  YES  NO (please provide a copy of the registration)

Other: \_\_\_\_\_

Were you in your own vehicle or someone else's at the time of the accident? Check one.

My own vehicle  my spouse's  my parent's  a friend's  other

If you were in someone else's vehicle, answer the following:

Name of Owner: \_\_\_\_\_

Address of Owner: \_\_\_\_\_

Do you reside with a family member who owns their own vehicle or is insured under some other auto policy? – Automobile insurance laws in applicable states require this info (check all that apply)

Spouse  Father  Mother  Guardian / Foster Parent  Grandparent  Sister / Brother  Child  None

Your Auto Insurance Company (at the time of accident): \_\_\_\_\_ Phone or City: \_\_\_\_\_

Agent: \_\_\_\_\_ Phone or City: \_\_\_\_\_

Was there any property damage to either of the vehicles as a result of the accident?

both vehicles  the other person's vehicle  the vehicle I was in  Neither vehicle was damaged

Have you been contacted by an adjuster from the other party's insurance company regarding this claim?  YES  NO

Adjuster: \_\_\_\_\_ Company: \_\_\_\_\_ Phone: \_\_\_\_\_

Check all that apply:  I have settled my personal injury claim with this company  I have settled the property damage claim

I have signed an agreement which will pay my medical expenses for a period of time (explain):

\_\_\_\_\_

I have not signed any agreement, nor settled any portion of my claim.

Are you currently represented by an attorney?  YES  NO If NO, do you wish to retain an attorney  YES  NO

Name of Attorney: \_\_\_\_\_ Phone or City: \_\_\_\_\_

**I have read, understood, and agree to the foregoing. The information which I have provided is true and complete to the best of my knowledge.**

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Guardian or Spouse's Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_