

AUTO ACCIDENT QUESTIONNAIRE

If your injuries are related to an auto accident, please fill out this form:

What was the approximate damage done to your vehicle: \$ _____

You were heading: North South East West on _____ (street or highway)

Were the police notified: Yes No Were you knocked unconscious: Yes No

Were you struck from: Behind Front Right Side Left Side

Did you have on a seat belt: Yes No Were you taken to the hospital: Yes No

If Yes, which hospital: _____ Were you released the same day: Yes No

What treatment was given (if any): _____

Did you feel pain immediately after the accident: Yes No Later that day Other

Did you consult a doctor after the accident: Yes No Doctor's name: _____

How often did you see the doctor: _____

How long did you see the doctor: _____

Have you ever had any complaints in the involved area before: Yes No

If yes, what were the complaints and how long ago: _____

Before the injury:

Were you capable of working on an equal basis with others of your age: Yes No

Were your work activities restricted in any way: Yes No

Were you experiencing pain in any part of your body: Yes No

If yes, please describe: _____

Since the injury:

Are your work activities restricted as a result of this accident: Yes No

Are your recreational activities more difficult to participate in: Yes No

Are your symptoms: Getting Better Getting Worse The Same