MOTOR VEHICLE COLLISION/PERSONAL INJURY QUESTIONNAIRE
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 ________________

MOTOR VEHICLE COLLISION/PERSONAL INJURY QUESTIONNAIRE Page 2

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# ______________________________________