VEHICLE ACCIDENT QUESTIONNAIRE

Name. _____SSI# _____Date _____

Date of Accident _____ Location of Accident_____

Were you driving? Yes No How many passengers? _____ Were you wearing a seat belt? Yes No

Do you remember hitting your head? Yes No Do you remember going unconscious? Yes No

Give make/model/color of your car _____

Give make/model/color of other car _____

Give details of how accident occurred: _____

_____

_____

_____

Please describe your injuries and symptoms at the time of injury _____

_____

_____

Did you receive any treatment following accident? Yes No Has any diagnosis been given? Yes No

What were you told was wrong? _____

Name of Doctor or facility _____When did you begin treatment? _____

What medication have you taken? _____

Describe your current complaints _____

_____

Are you currently take medication? Yes No What/Dosage/frequency_____

Have you missed any work as a result of this accident? Yes No How long have you been off work? _____

When did you return to work? _____ Has the injury restricted your work? Yes No

In what way? _____

****

Name of driver of the car you were in _____

Name of driver's insurance company _____

Name of other drivers insurance company _____

Name of adjuster _____Phone for Adjuster _____

Policy number_____ Claim number_____

****

Have you completed a Personal Injury Protection Application? Yes No

Agent Name _____ Phone Number_____

Claim Number /Policy Number _____

Attorney's name (if applicable) _____ Phone _____