2811 Lower Huntington Road • Fort Wayne, Indiana 46809-2616

Auto Accident Questionnaire

Name_______________________________ Date______________ (1)

YOUR INSURANCE COMPANY INFORMATION
(Name, Address, City, State, Zip, Phone Number, Adjuster, Claim Number)

____
____
____
____
____
____

Which company do we send this claim to?

____

Has the insurance company been notified of this accident?

____

ATTORNEY (Name, Address, City, State & Zip, Phone)

____
____
____
____

OTHER PERSON'S INSURANCE INFORMATION
(Name, Address, City, State, Zip, Phone Number, Adjuster, Claim Number)

____
____
____
____
____
____

OTHER DRIVER (Name, Address, City, State & Zip)

____
____
____
____
____

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Date of Accident______________

Location of Accident____

____

Please explain in detail how the accident happened:______________________________

____
____
____

Name_________________________________

Were you the driver: ____Yes____No

Passenger in front:___________________

Passenger in back:___________________

Did you have seat/lap belts on? ____Yes ____No

Does the car have head rests? ____Yes ____No

Were they fully extended? ____Yes ____No

Was the collision "Rear End" ____Yes ____No

Right front ____Yes ____No

Left front ____Yes ____No

Right side ____Yes ____No

Left side ____Yes ____No

Did you see it coming? ____Yes ____No

Did you brace yourself? ____Yes ____No

Was your head turned? ____Yes ____No

What direction?_____________________________

Did you strike your head? ____Yes ____No

What part of the car?__________________________

____

Did you lose consciousness ____Yes ____No

Were you dazed? ____Yes ____No

Were you dizzy? ____Yes ____No

Were you nauseated? ____Yes ____No

Did you have cuts or bruises? ____Yes ____No

Were you examined at the scene by paramedics or other medical personnel: ____Yes ____No

Did you go to the hospital? ____Yes ____No

Which one?__________________________________

Ambulance?___________________

Car?___________________

Did they do x-rays? ____Yes ____No

Did they do MRI? ____Yes ____No

Did they do other tests? ____Yes ____No

____

____

____

Date___________________

Did they tell you a diagnosis? ____Yes ____No

What?____

____

____

____

Did you go home? ____Yes ____No

Did you go to work? ____Yes ____No

Did you go to your Medical Doctor?______Yes_____No

When?____

Name of Doctor__________________________________

____

List medications prescribed______________________

____

____

Over the counter medication______________________

____

____

What were your symptoms or complaints at the scene of the accident?______________________________

____

____

____

Did your symptoms change later the same day or evening?_______________________________________

If so, please explain_____________________________

____

____

____

Were you experiencing any of these symptoms or complaints before this accident?________________

If so, please explain_____________________________

____

____

____

Name____ Date________________________

If you have neck, shoulder, elbow/arm, wrist, hand pain answer the following questions:

Where does your neck hurt? Left side Right side Upper Lower

How does it hurt? Circle any that apply:

Burning Pain Dull/Aching Localized Radiating Sharp Shooting StabbingThrobbing

Tightness Tingling Numbness

With head movements? Circle any that apply

Looking up Looking down Looking left Looking right

Leaning head to the left Leaning head to the right

Is the pain worse in the morning? _____ Afternoon _____ Night ____ With activity ___________

At rest rate the severity of the neck pain between 1-10, 1 no pain---10 extreme pain (cannot function) ____________________

When active rate the severity of the neck pain between 1-10, 1 no pain---10 extreme pain (cannot function) _______________

What are you unable to do because of the neck pain?____

Do you have headaches with your neck pain? Yes No

When did the headaches start? _________________________________How often do you have the headaches?____________

Are they right sided?_____________ Left sided?______ Base of the skull?________

What are you unable to do because of the headache(s)?____

****

Do you have shoulder/arm pain? Yes No Left Right

How does it hurt? Circle any that apply:

Burning Pain Dull/Aching Localized Radiating Sharp Shooting StabbingThrobbing

Tightness Tingling Numbness

At rest rate the severity of the shoulder/arm pain between 1-10, 1 no pain---10 extreme pain (cannot function) _____________

When active rate the severity of the shoulder/arm pain between 1-10, 1 no pain---10 extreme pain (cannot function) _

What are you unable to do because of the shoulder/arm pain?____

****

Do you have elbow/arm pain? Yes No Left Right

How does it hurt? Circle any that apply:

Burning Pain Dull/Aching Localized Radiating Sharp Shooting StabbingThrobbing

Tightness Tingling Numbness

At rest rate the severity of the elbow/arm pain between 1-10, 1 no pain---10 extreme pain (cannot function) _______________

When active rate the severity of the elbow/arm pain between 1-10, 1 no pain---10 extreme pain (cannot function) __________

What are you unable to do because of the elbow/arm pain?____

****

Do you have wrist/hand pain? Yes No Left Right

How does it hurt? Circle any that apply:

Burning Pain Dull/Aching Localized Radiating Sharp Shooting StabbingThrobbing

Tightness Tingling Numbness

At rest rate the severity of the wrist/hand pain between 1-10, 1 no pain---10 extreme pain (cannot function) _______________

When active rate the severity of the wrist/hand pain between 1-10, 1 no pain---10 extreme pain (cannot function) __________

What are you unable to do because of the wrist/hand pain?____

Name____ Date______________________

If you have back pain, answer the following questions:

Where does your back hurt?

_______Upper back	_______Left Side	_______Right Side	_______Midline
_______Between the shoulders	_______Left Side	_______Right Side	_______Midline
_______Low back (Above Waist)	_______Left Side	_______Right Side	_______Midline
_______Low back (Below Waist)	_______Left Side	_______Right Side	_______Midline

How does it hurt? Circle any that apply:

Pain Numbness Tingling Stiffness Soreness Weakness Swelling

Does your back hurt when you cough, sneeze, or take a deep breath? _______Yes _______No

Strain while having a bowel movement? _______Yes _______No

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Do you have hip pain? _______Yes _______No _______Left _______Right

How does it hurt? Circle any that apply:

Pain Numbness Tingling Stiffness Soreness Weakness Swelling

All the time? _______ After working all day? _______ In the early morning? _______

Do you have trouble using the hip? _______Yes _______No

****

Do you have leg pain? _______Yes _______No _______Left _______Right

How does it hurt? Circle any that apply:

Pain Numbness Tingling Stiffness Soreness Weakness Swelling

All the time? _______ After working all day? _______ In the early morning? _______

Do you have trouble using the leg? _______Yes _______No

****

Do you have knee pain?_______Yes _______No _______Left _______Right

How does it hurt? Circle any that apply:

Pain Numbness Tingling Stiffness Soreness Weakness Swelling

All the time? _______ After working all day? _______ In the early morning? _______

Do you have trouble using the knee? _______Yes _______No

****

Do you have ankle/foot pain? _______Yes _______No _______Left _______Right

How does it hurt? Circle any that apply:

Pain Numbness Tingling Stiffness Soreness Weakness Swelling

All the time? _______ After working all day? _______ In the early morning? _______

Do you have trouble using the ankle/foot? _______Yes _______No