Motor Vehicle Accident Questionnaire

Client name: Address:
Home phone: Work phone: Cell phone:
Birth date: Social Security Number:
Drivers License Number: State:

Collision

Date of accident:
Time:
Where did the accident occur?
What was the weather at the time of the collision? ☐ dry ☐ wet ☐ icy
Were you the: ☐ driver ☐ passenger ☐ pedestrian?
If passenger, were you in the ☐ front seat ☐ right rear seat ☐ left rear seat?
What type of vehicle were you in? What type was the other vehicle?
Did your vehicle strike the other vehicle? Yes ☐ No ☐
Was your car struck by the other vehicle? Yes ☐ No
What direction was your vehicle traveling?
What direction was the other vehicle traveling?
Where was the impact from?: ☐ the front ☐ the rear ☐ the left side ☐ the right side
What was the approximate speed at the time of the impact?
Your vehicle mph Other vehicle mph
Was your vehicle in: ☐ park ☐ neutral ☐ in gear ☐ moving ☐ stopped
Were you applying the brakes at the time of impact? Yes ☐ No
Please describe the collision in your own words:
Did any other part of your body hit the interior of the vehicle? Yes ☐ No ☐
If yes, please describe which body part and part of interior it hit:
Were you holding on to the steering wheel? Yes ☐ No ☐
Did the vehicle go into a spin or roll after the collision? Yes ☐ No ☐ If yes, describe:

Were there skid marks? Yes ☐ No ☐
Please describe the damage to the outside of the vehicle:
Please describe the damage to the inside of the vehicle:
Were you ☐ unconscious ☐ dazed ☐ conscious immediately after the accident?
If you lost consciousness, for how long?
Were you wearing a seat belt? Yes ☐ No If yes:
Did the belt have a shoulder harness? Yes ☐ No
Did the belt cause any pain? Yes ☐ No
Were you braced for the impact? Yes ☐ No ☐
Were you aware that an impact was coming? Yes ☐ No ☐
Was your vehicle thrust: ☐ forward ☐ backward ☐ sideways?
Were you thrust: ☐ forward ☐ whipped backward?
Were the air bags deployed? Yes ☐ No ☐

Did your seat have a head restraint (headrest?) Yes ☐ No ☐ If yes, was it positioned ☐ high ☐ midway ☐ low
Were you driving? Yes ☐ No ☐ If no, who was driving your vehicle?
Vehicle owner:
Describe how the accident happened:

Response to Accident

Did the police come to the scene of the accident? Yes ☐ No ☐
Were any citations issued or arrests made? Yes ☐ No ☐
Do you believe alcohol/drugs/medication was a factor in causing the accident? Yes ☐ No ☐ If yes, why?
Do you have a copy of the police report? Yes ☐ No ☐
Did you make any oral or written statements at the scene of the accident? Yes ☐ No ☐
If yes ,please describe statement and to whom:
Did you read and sign the statement? Yes ☐ No ☐
Do you have a copy of the statement? Yes ☐ No ☐
Did you make any oral or written statements after the accident, such as to an insurance adjuster? Yes ☐ No ☐ If yes ,please describe statement and to whom:
Did you read and sign the statement? Yes ☐ No ☐
Do you have a copy of the statement? Yes ☐ No ☐
Did anyone take pictures of the accident scene? Yes ☐ No ☐
Did anyone take pictures of your injuries? Yes ☐ No ☐
Witness information:

Name:	Address:	Home phone:	Work phone:	Cell phone:
Name:	Address:	Home phone:	Work phone:	Cell phone:
Name:	Address:	Home phone:	Work phone:	Cell phone:
Name:	Address:	Home phone:	Work phone:	Cell phone:

Injuries

Were you injured in the accident? Yes ☐ No ☐
Were you taken to the hospital? Yes ☐ No ☐
If yes, name of hospital: If yes, name of doctor:
If by ambulance, did the ambulance attendants place you in a ☐ neck brace ☐ back brace ☐ other
Did you get any medication or medical supplies? Yes ☐ No ☐ If yes, describe:
Did you have x-rays taken at the hospital? Yes ☐ No ☐
What medical treatment have you received?

How often did you see the doctor?
How long did you see the doctor?
Next visit scheduled:
Diagnosis:
Have you had any similar problems before? Yes ☐ No ☐
If yes, explain:
Have you ever been rejected for military service because of physical, mental, or other reasons? Yes ☐ No ☐ If yes, explain:
Do you wear glasses, contact lenses, or any prosthetic devices? Yes ☐ No ☐ If yes, explain:
Is there any limitation on your driver's license to operate? Yes ☐ No ☐ If yes, what is the limitation?
Have you ever been treated for alcohol or drug use? Yes ☐ No ☐ If yes, explain:

Have you ever been denied health or life insurance because of your health? Yes ☐ No ☐
If yes, by which company, and why?
Are you diabetic? Yes ☐ No ☐
Do you have high blood pressure? Yes ☐ No ☐
Do you have low blood pressure? Yes ☐ No ☐
Do you have arthritis or degenerative joint disease? Yes ☐ No ☐
Are you currently under medical care for injuries due to the accident? Yes ☐ No ☐

Insurance

Were you insured on the day of the accident? Yes ☐ No ☐ Do you carry uninsured motorist coverage? Yes ☐ No ☐ Do you have medical coverage for your automobile? Yes ☐ No ☐
Was the driver of the other vehicle(s) insured? Yes ☐ No ☐
Was the owner of the other vehicle(s) insured? Yes ☐ No ☐
Was the driver of the other car also its owner? Yes ☐ No ☐
Carrier of Client's Policy: Address:
Medical coverage? Yes ☐ No ☐ If yes, limits: Liability limits:
Collision coverage? Yes ☐ No ☐ If yes, limits:
Uninsured motorists coverage? Yes ☐ No ☐ If yes, limits:
Claim Number: Insured: Adjuster: Telephone Number: Ext.

Carrier of other driver's policy: Address:
Medical coverage? Yes ☐ No ☐ If yes, limits: Liability limits:
Collision coverage? Yes ☐ No ☐ If yes, limits:
Uninsured motorists coverage? Yes ☐ No ☐ If yes, limits:
Claim Number: Insured: Adjuster: Telephone Number: Ext.

Carrier of other owner's policy (if different from other driver):
Address:

Medical coverage? Yes ☐ No ☐ If yes, limits: Liability limits:
Collision coverage? Yes ☐ No ☐ If yes, limits:
Uninsured motorists coverage? Yes ☐ No ☐ If yes, limits:
Claim Number: Insured: Adjuster: Telephone Number: Ext.

Other Damages and Miscellaneous

List here every claim you have ever made for personal injury or property damage:

Date	Against Whom	Type of Claim	Lawsuit Filed	Result

What type of work do you do?
Have you lost any days of work from this injury? Yes ☐ No ☐
If yes, give dates:
Have you lost any overtime from work from this injury? Yes ☐ No ☐
If yes, give dates and times:
Was time off authorized by a doctor? Yes ☐ No ☐
Are your work activities limited due to this accident? Yes ☐ No ☐
Have you received any increases or decreases in your pay since the accident? Yes ☐ No ☐ If yes, describe:
Are other activities limited due to this accident? Yes ☐ No ☐ If yes, describe:

Have you received Social Security benefits or Medicare benefits as a result of this accident? Yes ☐ No ☐

Since this injury are your symptoms ☐ improving ☐ worsening ☐ same?

Where is the vehicle now?

Do you have a criminal record? Yes ☐ No ☐ If yes, please describe: