

AUTO INJURY QUESTIONNAIRE

Appt Date: _____ Appt Time: _____ Attorney: _____ Referred by: _____

YOUR INFORMATION:

Name: _____
Address: _____
Telephone: Home: _____ Work: _____ Cell: _____
Date of Injury: _____ Location of Accident: _____
Employer's Name: _____ Phone: _____
Employer's Address: _____
Hourly Wage: _____ Avg hours per week: _____ Contact Name: _____
Insurance Co: _____ Address: _____
Phone No: _____ Claim No: _____

OTHER DRIVER'S INFORMATION:

Name: _____
Address: _____
Telephone: Home: _____
Insurance Co: _____ Address: _____
Phone No: _____ Claim No: _____

VEHICLE INFORMATION:

Your Vehicle: Make: _____ Model: _____ Year: _____
Body Type: (circle) 2 door 4 door SUV Pick-Up Van Other: _____
Was there visible damage to your car? yes no
If yes, describe: _____
Do you know the repair estimate? yes no If yes, amount: \$ _____

Other Vehicle: Make: _____ Model: _____ Year: _____
Body Type: (circle) 2 door 4 door SUV Pick-Up Van Other: _____
Was there visible damage to the other car? yes no
If yes, describe: _____
Do you know the repair estimate? yes no If yes, amount: \$ _____

ACCIDENT INFORMATION:

You were the: Driver Passenger If passenger, where seated? _____
Time of day: _____ : _____ Day Night Sunrise/Dawn Sunset/Dusk
Weather: wet dry rain snow ice Other: _____
Road surface: dirt gravel asphalt concrete

AUTO INJURY QUESTIONNAIRE

Road Design: straight curved intersection
Traffic Control Device: None Stop Sign Light Other: _____
Was an accident report made? yes no To what agency? _____
Were the police on scene? yes no Which agency? _____
Were pictures taken of the vehicle? Yes No If yes, who took them: _____
Were you alone in the car? Yes No
If no, list all other people in the car: _____
Are there airbags in the car? Yes No
If yes, did the airbags deploy? Yes No Were you hit by the airbag? _____
If the airbag hit you, did it injure you? Yes No

WITNESSES:

Did any witnesses identify themselves: Yes No
If yes, provide their name and contact information: _____

INJURIES AND TREATMENT:

Were you aware that the collision was about to happen? Yes No
Did you have time to brace yourself? Yes No
Did your body hit anything inside the vehicle? seat belt head rest rear-view mirror
 steering wheel windshield door Other: _____
Did any of the windows break? Yes No
When were you first aware you were injured? within minutes hours days weeks
Where were you injured? head face neck chest
Shoulder: Left Right
Arm: Left Right
Leg: Left Right
Knee: Left Right
Ankle: Left Right
Were you treated at the scene by EMT's? Yes No
Were you transported to the hospital? Yes No How: _____
Were there any x-rays, MRI's or CT scans done? Yes No
Are you still being treated for your injuries? Yes No
If not, date you finished treatment: _____
Do you still have pain, numbness, tingling, etc from injuries? Yes No
If yes, describe: _____
Have you ever injured the hurt part of your body before this accident? Yes No
If yes, explain: _____

EMPLOYMENT INFORMATION:

Were you employed at the time of the accident? Yes No
If yes: Employer Name: _____
Employer Address: _____
Employer Phone Number: _____
Did you miss work because of your injuries? Yes No
If yes: Pay rate: \$ _____ / hourly monthly on salary
Average hours worked: _____ / day week
Estimated time lost: hours days