This form can be filled out on your computer prior to printing if you wish.

Date / /

ACCIDENT QUESTIONNAIRE

File#

First Name MI Last SS# - -

Date of Accident / / Time of Accident : am/pm

Location of Accident

Type of Accident ❑ Auto/Traffic ❑ Work/On Job ❑ At Home ❑ Other

Describe how the accident happened in your own words:

Immediately after the accident, how did you feel?

Were you unconscious ❑ Yes ❑ No In a daze? ❑ Yes ❑ No

Did you go to the hospital? ❑ Yes ❑ No

If Yes, when? ❑ At time of accident ❑ Next day ❑ Other

Did you go by; ❑ Private transport ❑ Ambulance ❑ Other

Name of Hospital Name of Doctor

Were x-rays taken ❑ Yes ❑ No What were the results/diagnosis

Were you admitted to the hospital ❑ Yes ❑ No How long did you stay?

What treatment was rendered?

What recommendations were made?

How did you feel the next day after the accident?

Doctors that you have seen as a result of this accident;

Have you lost any time from work as a result of this accident? ❑ Yes ❑ No If yes, give dates of disability

Totally from / / to / / Partially from / / to / /

Have you returned to work since the accident? ❑ Yes ❑ No If yes, complete the following:

Date	Employer	Occupation	Light/Regular Duty	Full/Part Time
/ /				

Since this accident occurred, are your symptoms: ❑ Improving ❑ Getting Worse ❑ Same

Have you noticed any activity restrictions as a result of this injury? ❑ Yes ❑ No If yes, please describe

Have you been contacted by an insurance adjuster or company representative about this accident? ❑ Yes ❑ No

If so, Name Phone# X

Have you retained an attorney ❑ Yes ❑ No Date attorney retained / /

Attorney Name Phone#

Address City State Zip

Patient Signature Date / /

First Name _____ MI ____ Last _____

Auto / Traffic Accidents

Was the accident reported to the Police Dept.? ❑ Yes ❑ No How many people were in your car? _____
What kind of vehicle were you in? ❑ Truck ❑ Car ❑ Motorcycle ❑ Other _____
Were you a ❑ Driver ❑ Front Passenger ❑ Left Rear Passenger ❑ Right Rear Passenger ❑ Pedestrian
Did your vehicle hit other vehicles? ❑ Yes ❑ No Estimated speed at impact _____ MPH
Was your vehicle hit by other vehicles? ❑ Yes ❑ No Estimated speed at impact _____ MPH
Other vehicle type? ❑ Truck ❑ Car ❑ Motorcycle ❑ Other _____
Direction of Impact: ❑ Front ❑ Rear ❑ Driver's Side ❑ Passenger's Side
Were you wearing a seatbelt? ❑ Yes ❑ No Did the airbag(s) deploy? ❑ Yes ❑ No
Did you strike anything as a result of the impact? ❑ Yes ❑ No
❑ Steering Wheel ❑ Dashboard ❑ Windshield ❑ Side door ❑ Arm rest ❑ Side window
What part of the body was hit: ❑ Chest ❑ Chin ❑ Knee ❑ Shoulder ❑ Hand ❑ Head ❑ Other _____

Regardless of who was at fault, please fill in both of the following boxes.

Vehicle You Were In	Other Vehicle
Insured	Insured
Address	Address
Phone #	Phone #
Auto Insurance Co	Auto Insurance Co
Ins. Co. Address	Ins. Co. Address
Adjuster	Adjuster
Policy #	Policy #
Claim #	Claim #

Have you reported the accident? ❑ Yes ❑ No Date Reported ___/___/___

Your insurance agent's name _____ Phone# (___) ___-____

All Accidents

In a typical 8-hour workday, I: (Check amount of each activity)

On the job I perform	Not at all	Occasionally	Frequently	Continuously
Bend / Stoop	❑	❑	❑	❑
Squat	❑	❑	❑	❑
Crawl	❑	❑	❑	❑
Climb	❑	❑	❑	❑
Reach above head	❑	❑	❑	❑
Kneel	❑	❑	❑	❑
Push / Pull	❑	❑	❑	❑
I lift up to	**Not at all**	**Occasionally**	**Frequently**	**Continuously**
0 – 10 lbs.	❑	❑	❑	❑
11 – 25 lbs	❑	❑	❑	❑
26 – 50 lbs	❑	❑	❑	❑
50+ lbs.	❑	❑	❑	❑

Patient Signature _____ Date ___/___/___