Auto Accident Questionnaire

Personal Information

Name: _____ Today's Date: _____

Phone: _____ SS#: _____

Height: _____ Weight: _____

In general, how would you rate your overall health:

Excellent Very Good Good Fair Poor

What kind of regular exercise do you get:

Strenuous Moderate Light None

Occupation:_____

What do you do at work:

Sits most of the day Stands most of the day Drives most of day

Manual labor Computer work

Other:_____

What do you do outside of work:

Bicycling Golfing Jogging Martial Arts

Walking Working Out Yoga Weight Lifting

Other:_____

Insurance Information

Your Insurance Company: _____ Policy Number: _____

Agent's Name: _____

Name on Policy (if other than self): _____

Responsible Party's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Policy Holder's Name: _____ Policy Number:_____

VanTil Chiropractic

Your Attorney's Information (if applicable)

Name: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Accident Description

Date of the accident: _____ Time of accident: _____ am / pm

How many vehicles involved: _____ Estimated $$ damage to your vehicle: _____

What road were you traveling on: _____

What direction were you traveling in: _____

City: _____ State: _____

Primary type of impact: *Mark One*

Your vehicle was rear-ended

Your vehicle hit other vehicle from behind

Your vehicle was hit on the driver's side

Your vehicle was hit on passenger's side

Where were you sitting in the vehicle: *Mark One*

Driver Front Passenger Rear Left Passenger Rear Right Passenger

Rear Passenger Other: _____

Did you know the accident was coming: *Mark One*

Unaware of impending collision

Aware of collision and relaxed

Aware of impending collision and braced

What type of vehicle were you in: *Mark One*

Crossover SUV SUV Compact Car Full Sized car

Truck Minivan Vehicle larger than 1 ton

Other: _____

Type of vehicle you impacted: *Mark One*

Crossover SUV SUV Compact Car Full Sized car

Truck Minivan Vehicle larger than 1 ton

Other: _____

At time of impact, your vehicle was: *Mark One*

Slowing down Stopped Gaining Speed Moving at steady speed

If moving, how fast in miles per hour: _____

At point of impact, other vehicle was: *Mark One*

Slowing down Stopped Gaining Speed Moving at steady speed

If other vehicle was moving, how fast in miles per hour: _____

During and after crash, what happened to your vehicle:

Kept going straight Kept going straight, hitting a car in front Spun around

Was hit by another vehicle Spun around and hit a stationary object

Hit a stationary object Other: _____

Did you lose consciousness during the accident:

Lost consciousness Remained conscious throughout entire accident

How was your head positioned during the accident : *Mark One*

Facing forward Turned to the left Turned to the right

Other: _____

Did your head hit any of the following: *Mark One*

Windshield Steering Wheel Side Door Dashboard

Seat Side Window Ceiling None

Other: _____

Did your shoulders hit any of the following: *Mark One*

Windshield Steering Wheel Side Door Dashboard

Seat Side Window Ceiling None

Other: _____

Did your chest hit any of the following: *Mark One*

Windshield Steering Wheel Side Door Dashboard

Seat Side Window Ceiling None

Other: _____

Did your knees hit any of the following: *Mark One*

Steering Wheel Side Door Dashboard

Side Window Seat None

Other: _____

Where was the headrest positioned on your head:

At the top of the back of head At the middle of the back of head

At the lower part of the back of head At the level of the back of neck

Other: _____

Did you have a seat belt on: Yes No

Did you have a shoulder harness on: Yes No

Did you go to the hospital: Yes No

If yes, how did you get there:

Ambulance Helicopter Police Car Drove yourself

Walked Other: _____

Who else have you received care from as a result of this accident:

_____

_____

What problems/complaints have occurred due to this accident:

_____

_____

Is there anything else you think the doctor should know:

_____

_____

_____

_____

_____

_____