

MOTOR VEHICLE ACCIDENT QUESTIONNAIRE

Name: _____ Date: _____

Date Injured: _____ Time: _____ AM/PM

Describe details of the accident: _____

Have you lost any days of work due to this injury? Y / N Dates: _____

Are you represented by an Attorney? Y / N Name: _____

Address: _____ Phone: _____

You were the: Driver Front Passenger Rear Passenger Pedestrian

in a: Car Truck Other: _____

that: Struck the other(s) Was struck by Car Truck Other: _____

Undetermined

Part of your vehicle hit: Back Front Right side Left side Other: _____

Part of their vehicle hit: Back Front Right side Left side Other: _____

Your vehicle was: Stopped for a traffic signal Stopped to make a turn Parked Moving at time of impact (describe above in Details of Accident section) Other: _____

List any other vehicles or objects involved: _____

You were wearing: Seatbelt Shoulder harness Both None

Airbag(s) opened: Driver Passenger Side None

At the time of impact, where were you looking and how were you positioned? _____

Did your body strike any part of the vehicle? Y / N Describe in detail: _____

Your estimated vehicle speed: _____ Their estimated vehicle speed: _____ Any Witnesses? Y / N

Was a traffic citations issued? Y / N You Driver of your car Driver of the other car

Was a police report written? Y / N Which city? _____

Were you rendered unconscious as a result of the collision? Y / N

Were you checked by EMS? Y / N What did they recommend? _____

Were you seen at an E.R.? Y / N Immediately Later that day Other: _____

Which hospital? _____

How did you get there? EMS Drive Taken by friend/spouse

What did they prescribe or recommend? _____

Have you seen any other doctors or had any treatment? Y / N

What did they prescribe or recommend? _____

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