

CAR CRASH & INJURY QUESTIONNAIRE

Name	Account	Date
------	---------	------

Date & Time of Accident _____

Describe how accident occurred and what happened to your body motion at the time of the accident.

How did you feel 24 hours before the accident?

FINE — NO PAIN _____

Were you	<input type="checkbox"/> Driver	<input type="checkbox"/> Passenger	Did you feel pain immediately	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Others in car	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Did seat back break	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Were they hurt	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Did glass break	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Wearing seat belt	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Do you have any cuts/bruises	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Wearing eye glasses	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Police report made	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Where were you hit	<input type="checkbox"/> Behind	<input type="checkbox"/> Front/Side	Did you go to E.R.	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Were you surprised	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Had accident before	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Were you leaning forward	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Missed any work	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Was your headrest	<input type="checkbox"/> High	<input type="checkbox"/> Low	<input type="checkbox"/> Center	Was car totaled	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Your head was facing	<input type="checkbox"/> Forward	<input type="checkbox"/> Right	<input type="checkbox"/> Left	Damage to vehicle	\$ _____	
Did you lose consciousness	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Speed of the vehicle that hit you	_____		
Speed of your vehicle	_____					

For insurance purposes please complete:

Type and Year of your vehicle _____

Your auto insurance co _____

Your auto agent _____ His/her phone number _____

This claim number _____

Adjusters name _____ Adjusters phone no. _____

Person who hit you _____ Type/Yr. of Vehicle _____

Their phone number _____ Their auto ins co. _____

This claim number _____

Your attorney _____

Telephone number _____

Address (if known) _____

Other Insurance Information

