MOTOR VEHICLE INJURY QUESTIONNAIRE

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Today's date:_____ Referred by:_____

Name: _____ Previous client: *Yes / No*
First Middle Last

Address: _____

_____

County of Residence: _____

Phone: Home: _____

Work: _____

Cell: _____

Date of Birth: _____

Social Security Number: _____

Driver's License # _____ State:_____

For Office Use Only

Statute of Limitations: _____

_____

Type:_____

Jurisdiction:_____

Family &/or friend who knows how to reach you at all times (address & phone numbers): _____

_____

ACCIDENT INFORMATION

Date of Accident: _____ Day of week: _____Time of day: _____

In your own words, please describe how the accident happened:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

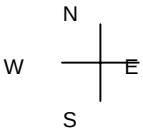
_____

_____

_____

_____

***Please draw a diagram of accident scene*:**



***Facts of the accident*:**

From where were you coming?_____

What was your intended destination? _____

In what direction were you traveling (North, South, East, West)? _____

In what direction was the other driver traveling? _____

What was your estimated speed prior to impact? _____

What was the posted limit? _____

Were police at the scene: *Yes / No (Please circle)*

Was it the: Local Police / Highway Patrol / Sheriff *(Please circle one)*

Were there citations issued? *Yes / No* To whom?_____

Was there an Ambulance/Paramedic: *Yes / No (Please circle)*

Who called the police or paramedic? _____

What were the weather conditions? _____

The pavement conditions?_____

Conversation at the scene:

What did you say?_____

What did other party say? _____

Were you wearing a seatbelt? *Yes / No (Please circle)*

Was any drinking involved? *Yes / No* By Whom?_____

List any Witnesses to the accident (including passengers):

Name	Address	Phone
Name	Address	Phone
Name	Address	Phone

INSURANCE INFORMATION

Your insurance information:

Were you the DRIVER? *Yes/No (Please circle)*

Were you the PASSENGER? *Yes/No (Please circle)*

Were you the OWNER of the vehicle? *Yes/No (Please circle)*

Your Insurance Company:_____

Agent: _____ Policy Number:_____

Do you have Stacking? *Yes / No (Please circle)*

Has a claim been reported to your insurance company? *Yes / No (Please circle)*

Did you give a statement? *Yes / No* If yes, to whom?_____

Was an Application for Benefits submitted? *Yes / No*

If you were a PASSENGER and DID NOT OWN the vehicle:

What is the vehicle owner's name?_____

Insurance company of vehicle owner:_____

Policy number:_____ Has claim been reported? *Yes / No*

Please list all vehicles that you or anyone in *your* household own:

Owner:_____Make and Model:_____Ins. Co._____

Owner:_____Make and Model:_____Ins. Co._____

Other driver's insurance information:

Name of other driver:_____

Owner of vehicle (if different than driver):_____

Insurance Company:_____

Policy Number:_____Agent:_____

Were **photos** taken of the vehicles involved? *Yes / No (Please circle)*

Of the accident scene? *Yes / No (Please circle)*

What is the current location of **your vehicle?**_____

Describe the damage to your vehicle:_____

What is the estimated amount of property damage to your vehicle?_____

Has your vehicle been repaired? _____

If yes, who repaired it? _____

Current location of **other vehicle?**_____

Describe the damage to the other vehicle:_____

EMPLOYMENT INFORMATION

Your Employer:_____Phone:_____

Address:_____

Dates of employment:_____ Job title:_____

Salary/Hourly Wages:_____ How many hours per week?_____

Please list your duties/job description:_____

_____

Have you missed any work to date? *Yes / No* *(Please circle)*

If yes, list the days and hours missed _____

Do you have a work release slip from doctor? *Yes / No* *(Please circle)*

Do you have a pay stub from the month prior to the accident? *Yes / No* *(Please circle)*

Did you file income taxes the previous year? *Yes / No* *(Please circle)*

PREVIOUS EMPLOYMENT HISTORY:

Name of employer and address:_____

_____

_____

Length of Employment:_____ Job Title:_____

MEDICAL HISTORY

CURRENT INJURY:

Please describe your symptoms at the scene of the accident:_____

_____

Did you go to the hospital directly from the accident scene? *Yes / No* Later? *Yes / No*

Which hospital?_____

Address of hospital:_____

If you did not experience symptoms at the scene, but later, please describe *when* and *what* they were:

_____

_____

What are your present symptoms?_____

Have you ever had these symptoms before? *Yes / No* If yes, please describe below:

_____

_____

List any other doctors or clinics with whom you have treated for this accident:

_____

_____

_____

PRIOR INJURIES/VEHICLE ACCIDENTS:

Please list *all* additional vehicle accidents in which you have been involved:

Date: Symptom/Injury: Treatment (Name & Address):

_____

_____

_____

_____

(use back if more space is needed)

Were there claims made on any of these injuries? *Yes / No (Please circle)*

If yes, which dates?_____

Do any symptoms remain from these prior injuries? *Yes / No (Please circle)*

PRIOR WORK-RELATED INJURIES:

Please list *all* work-related injuries:

Date: Symptom/Injury: Treatment (Name & Address):

_____

_____

Were there work-comp claims made on any of these injuries? *Yes / No (Please circle)*

If yes, which dates?_____

Do any symptoms remain from these prior injuries? *Yes / No (Please circle)*

If yes, please describe:_____

_____

PRIOR SLIP AND FALL INJURIES:

Date: Symptom/Injuries: Treatment (Name & Address):

_____

_____

PRIOR DOG BITES:

Date: Symptom/Injury: Treatment (Name & Address):

_____

_____

PRIOR RECREATIONAL OR ATHLETIC INJURIES:

Date: Symptom/Injury: Treatment (Name & Address):

_____

_____

ANY OTHER INJURIES:

Date: Symptom/Injury: Treatment (Name & Address):

_____

_____

Of all above listed injuries, did you have any settlements? *Yes / No* *(Please circle)*

If yes, please list injury and date:_____

_____

Who is your present General/Family Physician?

Name: Address: Phone:

_____

Who was your Health Insurance Carrier at the time of the accident? *(List below)*

Name: Address: Policy No:

_____

Have you had any significant illnesses or diseases (arthritis, diabetes, etc.)? *Yes / No* *(please circle)*

If yes, please list below:

Date: Type of illness/disease: Where and how you treated:

_____

_____

Have you ever treated with: (List name, address, and phone for all)

___Chiropractor:_____

___Neurologist:_____

___Orthopedist:_____

If you checked any of the above, please list your reason(s) for treatment: _____

_____

EDUCATION and HOME LIFE

Maiden Name/Aliases:_____

Marital Status: *Married / Single / Divorced* Name of Spouse:_____

Please list the names and ages of your children:_____

_____

Please list any additional household members names and ages: _____

_____

Mother's Name: _____Father's Name: _____

Where did you grow up (city and state)? _____

High School Name: City: Year of graduation:

_____

College/Vocational School Name: City: Year of graduation:

_____

Certificates/Degrees earned:

_____

Please list your recreational activities and hobbies:

_____

Have any of these activities been effected by your current accident? *Yes / No (Please circle)*

If yes, please list which ones:

_____

Is there anyone helping you with your household chores? *Yes / No (Please circle)*

Name of the person:_____

Are they being paid? *Yes / No* amount/per _____/_____