



AUTO ACCIDENT/WORKER'S COMP QUESTIONNAIRE

NAME: _____ DATE: _____ PATIENT # _____

ACCIDENT/INJURY DETAILS

DATE AND TIME OF ACCIDENT/INJURY: _____ DATE: _____ TIME: _____

PLEASE DESCRIBE THE DETAILS OF YOUR ACCIDENT: _____

WERE YOU WEARING YOUR SEAT BELT? _____ WHAT WAS THE APPROXIMATE SPEED OF YOUR VEHICLE? _____
WHERE WERE YOU SEATED? _____ WHERE WAS THE IMPACT OF YOUR VEHICLE? _____

IMMEDIATELY AFTER YOUR ACCIDENT/INJURY

- 1.) DID YOU LOSE CONSCIOUSNESS? _____
- 2.) WHERE DID YOU IMMEDIATELY DEVELOP PAIN? _____
- 3.) IF THERE WERE LACERATIONS, WHERE WERE THEY? _____
- 4.) DESCRIBE ANY OTHER SIGNIFICANT INJURY: _____

HOSPITAL VISIT AFTER ACCIDENT/INJURY

- 1.) DID YOU GO TO THE HOSPITAL? ____ IF YES, WHEN AND WHERE? _____
- 2.) WERE X-RAYS TAKEN? ____ IF YES, WHAT BODY PARTS? _____
- 3.) WHAT WAS THE DIAGNOSIS GIVEN AT THE HOSPITAL? _____
- 4.) WHAT WAS THE TREATMENT ADMINISTERED AT THE HOSPITAL? _____
- 5.) WERE MEDICATIONS SUBSCRIBED? ____ IF YES, WHICH MEDICATIONS? _____

FOLLOWING THE ACCIDENT/INJURY

- 1.) HOW MUCH LATER DID ADDITIONAL SYMPTOMS DEVELOP? IMMEDIATELY HOURS THAT EVENING NEXT MORNING DAYS WEEK MONTH
- 2.) WHAT ADDITIONAL SYMPTOMS DEVELOPED? _____
- 3.) ARE YOU RESTRICTED IN ANY OF THE FOLLOWING AREAS AS A RESULT OF THIS ACCIDENT/INJURY? _____
 DAILY LIVING WORK RECREATIONAL ACTIVITIES _____
- 4.) DID YOU SEEK ANY ADDITIONAL MEDICAL TREATMENT? ____ IF SO, WHAT TYPE OF PHYSICIAN? _____
NAME OF PHYSICIAN _____ DATE OF TREATMENT _____
DIAGNOSIS AND TREATMENT _____
- 5.) HAVE YOU EVER INJURED THIS AREA BEFORE? ____ IF SO, WHEN? _____
- 6.) SINCE THIS ACCIDENT/INJURY, ARE YOUR SYMPTOMS: IMPROVING GETTING WORSE THE SAME
- 7.) WHAT ARE YOUR DAILY JOB DUTIES? _____

INSURANCE/ATTORNEY INFORMATION

INSURANCE COMPANY _____ ADJUSTER/CASE WORKER NAME _____
ADJUSTERS PHONE NO. _____ CLAIM NO. _____
ATTORNEY _____ PHONE NO. _____

PATIENT'S SIGNATURE

DATE: _____