



PERSONAL (AUTO) INJURY QUESTIONNAIRE

Today's Date: / /

Name Attorney's Name

Date of accident Time of Accident (AM/PM) City and street of Accident

Road conditions at the time of the accident Wet Dry Icy Other

Did the police come to the accident scene? (Y / N) If Yes is there a report? (Y / N)

Were you: A) Driver B) Passenger (front) C) Passenger (rear left or rear right) D) Pedestrian

Were you wearing a seat belt? (Y / ) Shoulder Harness? (Y / N) Did you receive any injuries or bruises from the seat belt? (Y / N)

Number of people in your vehicle? Other vehicle?

If your vehicle was moving at the time of impact was it: A) slowing down B) gaining speed C) traveling at a steady rate of speed

If the other vehicle was moving at the time of impact was it: A) slowing down B) gaining speed C) traveling at a steady rate of speed

Type of vehicle: A) Auto B) Truck C) Van D) Motorcycle E) RV F) Bicycle Make and year of vehicle

Your approximate speed MPH Other vehicles approximate speed MPH

Where was your vehicle hit? A)Front B)Rear C)Rt. side D)Lft. side E)Rt. front F)Lft.front G)Rt. rear H) Lft. rear

Was the car still drivable from the scene? (Y / N)

What occurred at the moment of impact? (Circle as many as apply)

- A) Tensed body for impact B) Neck whipped forward & back C) Spine torqued and twisted D) Thrown over seat E) Thrown from side to side F) Pinned in vehicle G) Thrown from vehicle H) Cut and bruised

Was there a head rest in the car? (Y / N) Was it Stationary or Adjustable? S / A If adjustable, what position was it in?

How far away in inches was the back of your head from the Were you aware of the impending collision? (Y / N)

What position was your head in at the moment of impact? Were the brakes applied? (Y / N)

Did you strike your: (Circle as many as apply)

- A) Head Against the: 1) Dashboard 2)Windshield 3) Steering Wheel 4) Rt. Door 5) Lft. Door 6) Seat Frame 7) Unknown Object
B) Shoulder (Lft./Rt.) Against the: 1) Dashboard 2)Windshield 3) Steering Wheel 4) Rt. Door 5) Lft. Door 6) Seat Frame 7) Unknown Object
C) Arm (Lft./Rt.) Against the: 1) Dashboard 2)Windshield 3) Steering Wheel 4) Rt. Door 5) Lft. Door 6) Seat Frame 7) Unknown Object
D) Elbow (Lft./Rt.) Against the: 1) Dashboard 2)Windshield 3) Steering Wheel 4) Rt. Door 5) Lft. Door 6) Seat Frame 7) Unknown Object
E) Wrist (Lft./Rt.) Against the: 1) Dashboard 2)Windshield 3) Steering Wheel 4) Rt. Door 5) Lft. Door 6) Seat Frame 7) Unknown Object
F) Hip (Lft./Rt.) Against the: 1) Dashboard 2)Windshield 3) Steering Wheel 4) Rt. Door 5) Lft. Door 6) Seat Frame 7) Unknown Object
G) Knee (Lft./Rt.) Against the: 1) Dashboard 2)Windshield 3) Steering Wheel 4) Rt. Door 5) Lft. Door 6) Seat Frame 7) Unknown Object
H) Ankle (Lft./Rt.) Against the: 1) Dashboard 2)Windshield 3) Steering Wheel 4) Rt. Door 5) Lft. Door 6) Seat Frame 7) Unknown Object

Did you lose consciousness (black out) upon impact? (Y / N) For how

Did you receive medical attention at the scene of the accident? (Y / )

Where did you go immediately following the accident? A) Hospital B) Home C) Personal Doctor D) To this office E) Resumed

If you went to a hospital, what one did you go to and how did you get there?

What parts of your body were x-rayed at the hospital?

What did the hospital do for your injuries?

Were you wearing glasses or a hat? (Y / N) Were they still on after the accident? (Y / N)

Did you have any physical complaints before the accident? (Y / N) If YES please describe:

In your own words please describe the accident:

How did you feel immediately after the accident?