Accident Questionnaire

Name _____ Date _____

What kind of accident occurred? ____ auto ____ work ____ other

Please describe in detail how your accident happened:

_____

_____

_____

_____

When did this accident occur? Date of Accident _____ Time _____

What kind of symptoms have you had since this accident? (for example, low back pain, neck pain, headaches)

_____

_____

_____

How soon after the accident did you notice symptoms? _____

Have you ever had complaints like these before this accident? ___yes ___No
If yes, please explain: _____

Name of Insurance Company (responsible for your medical bills)_____

Policy Number _____ Claim Number _____

Do you have an attorney? ___yes ___ no

Name and address of Attorney _____

Have you lost time from work because of your accident? ___yes ___ no

If so, list dates you have been off work: _____

Were you hospitalized? ___yes ___no Name of Hospital _____

List any doctors you have seen for this condition _____

List any type of treatment you have been given for this condition

_____

_____