Accident Questionnaire

Name ______________________________ Date ____________________

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

Please describe in detail how your accident happened:

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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)

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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

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