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# CAR CRASH / MOTOR VEHICLE ACCIDENT QUESTIONNAIRE

**Your Name:** _____ **Today's Date:** _____/_____/_____

**Date of Accident:** _____/_____/_____ **Time (approx.)** _____

***If you were involved in an auto accident, please answer the following questions:***

**Describe what happened:** _____
_____
_____
_____

What kind of car were you in? (yr/make/model) : _____
What kind of car hit your car? (yr/make/model) : _____
**How many cars were involved?** ☐ 1 ☐2 ☐3 ☐ 4 ☐ >5
**How many impacts did you feel?** ☐ One ☐ More than one-specify_____
Did your car hit anything else? (eg, the car in front?) ☐**No** ☐**Yes** **If yes, what?**_____
**Estimate the speed of your car:** _____ Speed of the car that hit you: _____
**From which direction was your car hit?** ☐FRONT ☐ REAR ☐RT Side ☐ LFT Side ☐Multiple
**Road Conditions were:** ☐DRY ☐WET ☐ICY ☐SNOW ☐OTHER

**Describe what happened to you physically:**_____
_____
**Was the driver's foot on the brake?** ☐ Yes ☐No **Did an airbag deploy ?** ☐Yes ☐No ☐No airbag
**Where were you in the car?** ☐Driver ☐Front Passenger ☐Rear Passenger
**Were you wearing a seatbelt?** ☐**No** ☐**Lap belt only** ☐**Shoulder belt only** ☐**Both lap & shoulder**
**Did the impact take you by surprise?** ☐Yes ☐No **Did you brace yourself?** ☐Yes ☐No
**Did your body strike anything? (eg, door, windshield)** ☐No ☐Yes –specify_____
**Were you knocked unconscious?** ☐No ☐Yes ☐Dazed ☐Don't remember
What is the **last thing** your remember before the crash? _____
What is the **first thing** you remember after the crash? _____
**Did you hit your head?** ☐**No** ☐ **Yes** **If yes, describe?**_____
**How was your head positioned:** ☐Looking forward ☐Turned right ☐Turned left ☐Other:_____
**Did you have any:** ☐Cuts? ☐Scrapes? ☐Bruises? ☐Swelling? Describe:_____
**When did you first notice symptoms?** ☐Immediately ☐Minutes ☐Hours ☐Days
**Have your symptoms been:** ☐Getting progressively worse ☐ Staying the same ☐Getting better
**Were you examined at the accident scene?** ☐No ☐Yes_____
**Have you been examined in the Hospital/Emergency Room?** ☐No ☐Yes_____
**Have you received any treatment since?** ☐No ☐Yes_____
**How much damage was done to your car?** About $_____ ☐Total Loss ☐Unsure
**Have you lost any time from work since the accident?** ☐No ☐Yes: _____
**Were you having any symptoms before the accident ?** ☐No ☐Yes: describe:_____
**Have you been injured in any previous accident?** ☐No ☐Yes : describe:_____

***INSURANCE & LEGAL INFORMATION:***
**Your Auto Insurance Information:** Company_____Adjuster_____Ph:_____
Policy No._____Claim Filed? ☐No ☐Yes : Cl #. _____
**Other Party's Auto Insurance:** Company_____ Adjuster_____
Policy No._____ Claim Filed? ☐No ☐Yes : Cl #. _____
**Have you retained an attorney?** ☐No ☐Yes if yes, Name:_____Phone#_____