PREMIER CHIROPRACTIC AND REHAB

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AUTOMOBILE ACCIDENT QUESTIONNAIRE

Please answer all questions completely.

Name:_____ Date of Accident:_____ Time:_____

Driver of vehicle in which you were injured: _____

Insurance Company: _____ Policy #:_____

Claim#_____ Phone #:_____

Driver of other vehicle: _____ Policy#:_____

Insurance Company#:_____ Claim#:_____

Adjuster:_____Phone#:_____

Have you retained an attorney? ___Yes ____No Attorney's Name: _____

Address: _____ Phone#:_____

Describe the accident in detail: _____

Were police notified? ___Yes ___ No

What was your position in the car? ____ Driver ____ Passenger

If passenger, where were you sitting in the car? ___ Front ___ Right Rear ___ Left Rear

What type of vehicle were you in? _____

You were heading? ___ North ___East ___ South ___ West on _____(street or highway)

Other vehicle was headed? ___ North ___East ___ South ___ West on _____(street or highway)

Was the impact from the: ___ Front ___Right Side ___ Left Side ___ Rear

Was the vehicle in: ___Park ___Neutral___ In Gear ___ Moving ___ Stopped

Were brakes being applied? ___ Was vehicle being shoved? ___ Forward ___ Backwards ___ Sideways

Were you shoved forward and whipped backwards at a rapid force, while hitting your head?_____

Did your head override headrest and springboard forward? _____

Did your hat or glasses end up in the back seat or under the rear window? ___ Yes ___ No

Did any part of your body hit any part of the interior? ___ Console ___ Steering Wheel ___Dashboard ___Windshield ___ Arm Rest ___ Side Door Window ___ Part of Body

Parts of body: ___Chest ___Chin ___Knee ___ Shoulder ___ Hand ___ Head

Were you wearing your seatbelt? ___Yes ___ No Did they break upon impact? ___ Yes ___ No