PERSONAL INJURY QUESTIONNAIRE

PATIENT NAME:_____ DATE:_____ FILE#_____

●Your auto insurance company_____Policy#_____Claim#_____

●Was an accident report filed with the police? □Yes □No

●Driver of other vehicle_____ Insurance company_____Claim#_____

●Have you retained an attoney? □Yes □No

If yes, attorney's name/firm/phone#_____

Nature of MVA Accident

●Date of accident:_____ Time of Day:_____□am □pm

Location_____

●Police Investigation by: □Caldwell Police □Nampa Police □Meridian Police □Boise Police □Canyon County Sheriff □Ada County Sheriff □Idaho State Patrol □No Investigation

□Other_____

●Road conditions at the time of the accident: □Dry □Wet □Icy □Snow □Fog □Other_____

●Where were you seated in the vehicle: □Driver □Front Seat Passenger □Back Seat Passenger

●Where you aware of the approaching collision prior to impact, or were you caught by surprise?

□Aware of the approaching collision □Caught by surprise

●Did you lose consciousness upon impact: □Yes □No If yes, for how long_____?

●Was the vehicle equipped with headrest? □Yes □No

●Were you wearing a seat belt? □Yes □No If so, what type □Shoulder/Lap belt □Lap belt

●Was the car equipped with an airbag? □Yes □No If yes, did the airbag deploy? □Yes □No

●Where you struck from: □Behind □Front □Left side □Right side

●Was your car stopped at the time of impact? □Yes □No

If yes, was the driver's foot on the brake? □Yes □No □Don't know

If the driver's foot was on the brake, was it pressing down: □Slightly □Moderately □Strongly

If no, then estimate the speed of the vehicle you were in_____m.p.h.

●If your vehicle was moving at the time of the collision, was it slowing down, gaining speed, or traveling at a steady speed? □Slowing down □Gaining speed □Steady speed

●Number of people in your vehicle?_____

●Please describe, to the best of your knowledge, what happened during the accident:

_____

_____

●What type of car were you in? (year, make, & model)_____

PERSONAL INJURY QUESTIONNAIRE

PATIENT NAME:_____ DATE:_____ FILE#_____

●What type of car impacted with your vehicle? (year, make, & model)_____

●Was the other vehicle moving at the time of the collision? □Yes □No

If yes, what was its approximate speed:_____m.p.h.

●If the other vehicle was moving at the time of the collision, was it slowing down, gaining speed, or traveling at a steady speed? □Slowing down □Gaining speed □Steady speed

●What bruises or cuts did you get from the accident?_____

●On what part of the automobile did the following body parts hit:

Head hit_____ Chest hit_____

Right shoulder hit_____ Left shoulder hit_____

Right arm hit_____ Left arm hit_____

Right hip hit_____ Left hip hit_____

Right leg hit_____ Left leg hit_____

Right knee hit_____ Left knee hit_____

Other_____

●What position was your head facing upon impact? □Forward □Right □Left □Other_____

●What position was the trunk of your body facing upon impact? □Forward □Right □Left □Other_____

●Was your vehicle pushed/moved from the impact? □Yes □No

If yes, how much? □One car length □More then one car length □One-half car length

□Less than one-half car length

●Did your car hit anything else after it was hit?_____

●Describe the damage to your vehicle: □None □Minimal □Moderate □Major □Totaled

●Which of the following car parts broke during the accident? □Windshield □Front seat back □Driver's side window □Passenger side window □Steering wheel □Other_____

●Estimate given for damage to your vehicle: $_____ □Estimate not yet obtained

●Describe the damage to the other vehicle(s): □None □Minimal □Moderate □Major □Totaled

●Who was at-fault for the accident? □Driver of the other car □Driver of the car I was in

□Myself □Undetermined

●Was anyone cited?_____

PERSONAL INJURY QUESTIONNAIRE

PATIENT NAME:_____ DATE:_____ FILE#_____

Emergency Care

●At the site of the accident, did you receive emergency care? □Yes □No

Describe:_____

●Where did you go after the accident? □ER □Doctor's office □Home □School □Work

●When did you receive care? □Immediately □Later that day □Next day □Days later, date_____

●By whom were you driven? □Ambulance □Self □Family member □Friend

Treatment

●Hospital name:_____ (or) other medical facility_____

●What type of treatment receive?_____

●Were x-rays taken? □Yes □No

●Medication prescribed:_____

●What recommendations were you given?_____

●Have you been treated by any other doctor(s) for injuries related to this accident? □Yes □No

If yes, please list doctors and briefly describe treatment:

1._____Dates of Care _____Type of Care_____

2._____Dates of Care _____Type of Care_____

3._____Dates of Care _____Type of Care_____

4._____Dates of Care _____Type of Care_____

Present Symptoms

●What are your present complaints and symptoms?

_____

_____

_____

●Did you have similar symptoms before the accident? □Yes □No If yes, describe any changes or worsening_____

_____

_____

Prior History

●Have you ever been involved in a motor vehicle accident before? □Yes □No If yes, briefly describe, including dates and injuries received:_____