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PERSONAL INJURY QUESTIONNAIRE
(Automobile Accident)

Name: _____ Date of Birth: _____
Address: _____ City: _____
State: _____ Zip Code: _____ Home Phone No: () _____
Employer: _____ Work Phone No: () _____
Address: _____ Your Social Security No: _____
Your Insurance Company: _____ Policy No: _____
Insured's Name: _____ Agent's Name / Phone No: _____
Have you retained an Attorney? Yes No If YES, Attorney's Name/Phone _____

NATURE OF ACCIDENT

Date of Accident: _____ Time of Day: _____ A.M. P.M.
Was your head rotated? _____ If Yes, which direction? Left Right
Were you: Driver Passenger Front Seat Back Seat
Were you rotated in your seat: Yes No If YES, which direction? Right Left
What direction were you headed? North South East West
on (Name of Street) _____ at _____ miles per hour.
Was traffic: Heavy Moderate Light In What City: _____
Were you hit from: Behind Front Left Front Right Front Left Rear Right Rear
Were you aware of the impact coming? Yes No Approximate speed of the other car? _____
Condition of the Road / Weather: Wet Dry Ice Fog Sleet Hail Bright Sun
 Strong Winds Construction Heavy Traffic Other _____
Were you wearing: Seatbelt Shoulder Harness Both _____
Did the Airbag open? Yes No If YES, Driver's Side Passenger's Side Both
Were you knocked unconscious? Yes No For how long? _____
Did you have any physical complaints BEFORE THE ACCIDENT? Yes No If YES, please describe:

PLEASE DESCRIBE HOW YOU FELT:

DURING the Accident: _____

IMMEDIATELY AFTER the Accident: _____

LATER THAT DAY: _____

