

# PERSONAL INJURY PROTECTION QUESTIONNAIRE

Name \_\_\_\_\_ Date of Accident \_\_\_\_\_ Time \_\_\_\_\_

Please describe the accident in your own words \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please answer the following questions regarding your accident and injury.

1. What was your position in the car?    \_\_\_ driver    \_\_\_ passenger  
\*If passenger, were you in    \_\_\_ front seat    \_\_\_ right rear seat    \_\_\_ left rear seat
2. Were you wearing a seat belt?    \_\_\_ yes    \_\_\_ no  
\*If so, what type?    \_\_\_ lap    \_\_\_ shoulder
3. Did your seat have a head restraint (headrest)?    \_\_\_ yes    \_\_\_ no  
\*If so, what was the position of the head restraint?    \_\_\_ low    \_\_\_ mid position    \_\_\_ high
4. Did your vehicle strike the other vehicle?    \_\_\_ yes    \_\_\_ no
5. Was your vehicle struck by the other vehicle?    \_\_\_ yes    \_\_\_ no
6. Was the impact from:    \_\_\_ the front    \_\_\_ the rear    \_\_\_ the left side    \_\_\_ the right side
7. What was the approximate speed at the time of impact?  
\*Your vehicle    \_\_\_ mph  
\*Other vehicle    \_\_\_ mph
8. What were the road conditions?    \_\_\_ dry    \_\_\_ wet    \_\_\_ icy
9. At the time of impact were you:    \_\_\_ looking straight ahead    \_\_\_ looking to the right  
\_\_\_ looking to the left    \_\_\_ looking down    \_\_\_ looking up
10. Were both hands on the steering wheel?    \_\_\_ yes    \_\_\_ no  
\*If no, which hand?    \_\_\_ right    \_\_\_ left
11. Was your foot on the brake?    \_\_\_ yes    \_\_\_ no  
\*If so, which foot?    \_\_\_ right    \_\_\_ left
12. Were you braced at the time of impact?    \_\_\_ yes    \_\_\_ no
13. Did you strike anything at the time of impact?    \_\_\_ yes    \_\_\_ no  
\*If so, please specify    \_\_\_ seat belt restraints    \_\_\_ steering wheel    \_\_\_ dashboard  
\_\_\_ windshield    \_\_\_ side door    \_\_\_ side window    \_\_\_ other \_\_\_\_\_  
  
\*Please state part of body:    \_\_\_ chest    \_\_\_ head    \_\_\_ chin    \_\_\_ face  
\_\_\_ r/l knee    \_\_\_ r/l shoulder    \_\_\_ r/l hand    \_\_\_ other \_\_\_\_\_

14. You were heading:  north  east  south  west on \_\_\_\_\_ (street or highway)

15. Other vehicle was headed:  north  east  south  west on \_\_\_\_\_ (street or highway)  
Were police notified?  yes  no

16. Immediately after the accident were you:  conscious  dazed  unconscious

17. Did you go to the hospital?  yes  no  
\*If so, when?  at the time of accident  next day  other \_\_\_\_\_

18. How did you get to the hospital?  ambulance  private transportation  
\*If by ambulance, did the ambulance attendants place you in a:  neck brace  
 back brace  other \_\_\_\_\_

19. If you went to the hospital, please answer the following:  
\*Name of hospital \_\_\_\_\_  
\*Name of doctor \_\_\_\_\_  
\*Diagnosis \_\_\_\_\_  
\*Treatment received \_\_\_\_\_

20. Your insurance company \_\_\_\_\_ Policy Number \_\_\_\_\_ Claim Number \_\_\_\_\_

21. Driver of other vehicle (if any)  
Name \_\_\_\_\_ Insurance Company \_\_\_\_\_ Policy Number \_\_\_\_\_

22. Driver of vehicle in which you were injured (if applicable)  
Name \_\_\_\_\_ Insurance Company \_\_\_\_\_ Policy Number \_\_\_\_\_

23. Name of your insurance adjustor \_\_\_\_\_

24. Have you retained an attorney?  yes  no  
\*If so, their name, address, and phone number \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Patient Signature Social Security Number

Doctor Use Only

Requested medical records from:  
1. \_\_\_\_\_  
2. \_\_\_\_\_  
3. \_\_\_\_\_

Requested accident report

Accident Questionnaire reviewed with patient by Dr. \_\_\_\_\_