



Your Wellness Connection, P.A.

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Automobile Accident Questionnaire

Please completely answer all questions that apply.

Client Name _____ D.O.B. _____

Accident Details . . .

How did accident happen? _____

Driver of other vehicle: _____ Accident Time: _____ AMPM Date: ___/___/___

Insurance Company: _____ Phone Number: _____

Policy Number: _____ Claim Number: _____

Name of driver of vehicle in which you were injured (self or other): _____

Insurance Company _____ Phone Number: _____

Policy Number: _____ Claim Number: _____

Were you traveling north south east west on _____ (street or highway)

Number of people in vehicle _____ Police called? yes no State _____ Work Related: yes no

You were driver passenger front seat back seat using seat belts other protective devices

Injuries . . .

Did head strike object? yes no Knocked unconscious? yes no How long? _____

Struck from behind front left side right side

Immediate pain yes no when? _____ Location of pain _____

How were you transported? _____ Hospital _____

Any problem in injured area prior to accident? yes no What? _____

Care . . .

Where were you taken after accident? _____

Treatment given _____

Doctor attending _____ D.C. M.D. D.O. D.D.S.

Diagnosis _____ Number times seen by Doctor _____

Length of care provided _____ Injury resulting in permanent disability? yes no

Activities . . .

Before injury, capable of working on equal basis with others your age? yes no

As result of accident, are work activities restricted? yes no

Since injury, symptoms improving getting worse the same permanently disabled

Client Signature: _____ Date: _____