

ACCIDENT & INJURY QUESTIONNAIRE

Name	Account	Date
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Automobile Accident

Date & Time of Accident _____

Describe how accident occurred and what happened to your body motion at the time of the accident.

How did you feel 24 hours before the accident?

FINE — NO PAIN _____

- | | | |
|---------------------|----------------------------------|-------------------------------------|
| Were you | <input type="checkbox"/> Driver | <input type="checkbox"/> Passenger |
| Others in car | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Were they hurt | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Wearing seat belt | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Wearing eye glasses | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Where were you hit | <input type="checkbox"/> Behind | <input type="checkbox"/> Front/Side |
| Damage to vehicle | <input type="checkbox"/> Minimal | <input type="checkbox"/> Moderate |
| Was car totaled | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Did seat back break | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Did glass break | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Police report made | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Did you go to E.R. | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Had accident before | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Missed any work | <input type="checkbox"/> No | <input type="checkbox"/> Yes |

For insurance purposes please complete:

Your auto insurance co _____
Your auto agent _____
His/her phone number _____
This claim number _____
Adjusters name _____
Adjusters phone no. _____

Person who hit you _____
Their phone number _____
Their auto ins co. _____

Your attorney _____
Telephone number _____
Address (if known) _____

Other Insurance Information

Work Related Injury

Date & Time of Accident _____

Describe how injury occurred in your own words. Be specific in details & accurate in pains & injuries.

How did you feel 24 hours before this injury?

FINE — NO PAIN _____

- | | | |
|-------------------------------|-----------------------------|------------------------------|
| Was injury report made | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Report to supervisor | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Missed any work | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Had any work injury before | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Seen company doctor yet | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Were you authorized to see us | <input type="checkbox"/> No | <input type="checkbox"/> Yes |

List your routine job duties in detail

For insurance purposes please complete:

Employer/Company _____
Your supervisor _____
Company phone no. _____
Company doctor name _____
Doctors phone number _____
Your med insurance _____
Your policy number _____

Your attorney _____
Telephone number _____
Address (if known) _____

Other Insurance Information

