Pro Natural Health Center医本堂
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AUTO ACCIDENT QUESTIONNAIRE Today's Date: _____

Name: Last _____ First _____ M.I. _____

Accident Date (M/D/Y): _____Accident Time: _____

Please briefly describe what happened:

_____

Was your vehicle struck by another vehicle / object? Y ◯ N ◯

Did your vehicle strike another vehicle/object? Y ◯ N ◯

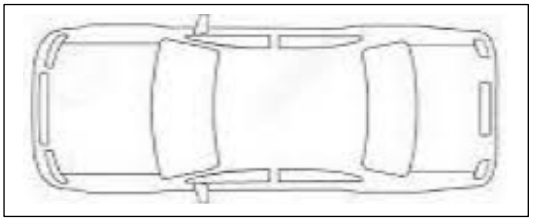
Where you at fault for the accident? Y ◯ N ◯

Did the airbag deploy? Yes ◯ No ◯ N/A ◯

Your position: Driver: F. Right: ◯ R. Left: ◯ R. Right: ◯

What direction were you facing? Forward: ◯ Left: ◯ Right: ◯

Indicate the point(s) of impact



Did you brace for the impact? No ◯ Braced with hand ◯ Braced with feet ◯

What was your approximate speed at the time of impact? _____mi/hr

Were you: Stopped: ◯ Gaining speed: ◯ Slowing down: ◯ Driving at a steady rate: ◯

What was the approximate speed of the other vehicle (if it's not an object)? _____mi/hr

Were you wearing a seat belt? Lap belt: ◯ Shoulder and lap belt : ◯ No belt: ◯

Were you knocked unconscious? Yes ◯ No ◯ If yes, how long? _____hr

Did your body strike anything in your vehicle at the time of impact? Yes ◯ No ◯

If yes, explain: _____

Describe how you felt (physical complaints):

DURING the accident: _____

IMMEDIATELY AFTER the accident: _____

LATER THAT DAY: _____

THE NEXT DAY:_____

PRESENT complaints / symptoms: _____

Since the accident, these complaints / symptoms have gotten: Better ◯ Same ◯ Worse ◯

Did you go to the hospital after the accident? Yes ◯ No ◯

If yes, what kind of treatment did you receive? _____

X-rays: Yes ◯ No ◯ If yes, any findings: _____

Any treatment related to the accident? Yes ◯ No ◯

If yes, explain: _____

Have you retained an attorney for the case? Yes ◯ No ◯

Attorney'sname: _____ Phone _____

Attorney's email: _____

INSURANCE INFORMATION:

Insurance name: _____ Case #:_____

Adjuster name:_____ Phone:_____ Ext: _____

Email: _____ Other Info: _____

Patient Signature: _____Date: _____