

# PERSONAL INJURY PROTECTION QUESTIONNAIRE

Name \_\_\_\_\_ Date of accident \_\_\_\_\_ Time \_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## **Please answer the following questions regarding your accident and injury.**

1. What was you position in the car?  Driver  Passenger  
If passenger, were you in the:  Front  Right Rear  Left Rear
2. Were you wearing a seat belt?  Yes  No  
If so, what type?  Lap  Shoulder
3. Did your seat have a head restrain (headrest)?  Yes  No  
If so, what position was it in?  Low  Mid-position  High
4. Did you vehicle strike the other vehicle?  Yes  No
5. Was you vehicle struck by another vehicle?  Yes  No
6. Was the impact from the:  Front  Rear  Left Side  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  To the Right  To the Left  
 Down  Up
10. Were both hands on the steering wheel?  Yes  No  
If no, which hand?  Left  Right
11. Was you foot on the brake?  Yes  No  
If no, which foot?  Left  Right
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.  Seatbelt 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. Immediately after the accident, were you:  Conscious  Dazed  Unconscious

15. Did you go to the hospital? \_\_\_\_ Yes \_\_\_\_ No

16. 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 \_\_\_\_\_

17. If you went to the hospital, please answer the following:

Name of Hospital \_\_\_\_\_

Name of Doctor \_\_\_\_\_

Diagnosis \_\_\_\_\_

Treatment Received \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

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**FOR DOCTOR'S USE ONLY**

Picture

Pt Vehicle # 1

Other Vehicle # 2

\_\_\_\_ Request medical records from:

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

\_\_\_\_ Requested accident report

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