AUTO ACCIDENT QUESTIONS

(Form AAQ2017)

Name _____ Date _____

1) Did this accident occur while at work? Yes No
2) When did the accident happen *(Date)*: _____
3) Where did the accident happen? *(State & Road or Intersection)* _____
4) Year, Make & Model of vehicle you were in: _____
5) (If collision with another vehicle) The other vehicle's type _____
6) Were you the driver? Yes No
   A) (If No) Where were you sitting as passenger? _____
7) Were you wearing a seatbelt? Yes No
8) Did your airbag deploy? Yes No
9) What were the road conditions? (wet, dry, icy, gravel, pavement) _____
10) Side, front, or Rear-end impact?

_____

_____

11) Was your vehicle stopped or moving at the moment of impact? _____
12) Was your vehicle drivable after the accident? Yes No
13) Did you brace yourself? Yes No
14) How many vehicles were in the collision? _____
15) How did you feel immediately following the collision? _____

_____

16) What did you feel hours or days later? _____

_____

17) Were you knocked unconscious? Yes No
18) Did you go to the emergency room? Yes No
   A) (If Yes) What was done at the ER?

      _____

      _____

19) Have you had any treatments before coming to our office today? Yes No
   A) (If Yes) What kind of treatments?

      _____

   B) (If Yes) How did those treatments help?

      _____

      _____

20) Have you had an auto accident in the past? Yes No
   A) (If Yes) what areas of the body were you injured?

      _____

21) What symptoms were you having before this collision? _____
22) Have you retained an attorney? Yes No
   A) (If Yes) Name and address: _____

_____

Sign & Date