

**Dr. Mitchell D. Simon**  
**Chiropractic Physician**  
**AUTOMOBILE INJURY QUESTIONNAIRE**

Your Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Date of Accident: \_\_\_\_\_ Time of Accident: \_\_\_\_\_ am / pm

City of Accident: \_\_\_\_\_ Street of Accident: \_\_\_\_\_

Road conditions at the time of the accident: WET DRY ICY OTHER \_\_\_\_\_

Did the police come to the accident scene? YES NO; Is there a report? YES NO

Did you go to a hospital? YES NO

If yes, what is the name and city of the hospital? \_\_\_\_\_

How did you get to the hospital? \_\_\_\_\_

What parts of your body were x-rayed at the hospital? \_\_\_\_\_

What did the hospital do for your injuries? \_\_\_\_\_

How long did you stay at the hospital? \_\_\_\_\_

What bleeding cuts did you sustain during this accident? \_\_\_\_\_

What bruises did you sustain during this accident? \_\_\_\_\_

Where were you seated in the vehicle? \_\_\_\_\_

Were you aware of the approaching collision prior to impact, or did impact catch you by surprise? AWARE SURPRISE

Did you lose consciousness (black out) upon impact? YES NO; How long: \_\_\_\_\_

Do you remember the actual collision? YES NO

Did you experience a flash of light or explosion in your head? YES NO

Did you become CONFUSED DISORIENTED LIGHT HEADED  
DIZZY NAUSEATED BLURRED VISION RING/BUZZ IN EARS  
from the accident? ( please circle )

If you still have any of those symptoms, which ones? \_\_\_\_\_

Are you currently suffering from any of the following (please circle)

RESTLESSNESS IRRITABLE  
DIFFICULT CONCENTRATING DIFFICULT WITH MEMORY  
SLEEPLESSNESS FORGETFULNESS  
REDUCED TOLERANCE TO HEAT REDUCED TOLERANCE TO ALCOHOL

What is the approximate distance between the back of your head and your vehicle's headrest? \_\_\_\_\_ inches

Did your head go back over the top of your vehicle's headrest? YES NO

Were you wearing a seatbelt? YES NO  
If yes, was it a lap seatbelt \_\_\_\_\_ shoulder-lap seatbelt \_\_\_\_\_

Does your vehicle have an airbag? YES NO

Did the airbag deploy in this accident? YES NO

Did you receive an injury from the airbag? YES NO

Please describe: \_\_\_\_\_

List the year, make and model of the vehicle you were in:

Year \_\_\_\_\_ make \_\_\_\_\_ model \_\_\_\_\_

Was your car stopped at the time of impact? YES NO

If yes, was the driver's foot also on the brake? YES NO

If no, then estimate the speed of the vehicle you were in: \_\_\_\_\_ mph

On what part of the automobile did your following body parts hit?

Head hit \_\_\_\_\_ chest hit \_\_\_\_\_

Right/left shoulder hit \_\_\_\_\_ right/left arm hit \_\_\_\_\_

Right/left hip hit \_\_\_\_\_ right/left leg hit \_\_\_\_\_

Right/left knee hit \_\_\_\_\_ other \_\_\_\_\_

Did you receive any injury or bruise from the seat belt ( i.e. breast or abdomen ) ?

YES NO

If YES, then describe: \_\_\_\_\_

What is the estimated cost damage to the vehicle you were in? \$ \_\_\_\_\_

Which of the following car parts broke during the accident? (please circle)

Windshield front seat back

Right/left side window other \_\_\_\_\_

Steering wheel other \_\_\_\_\_

Was the trunk of your body pointed straight forward at the time of the collision?

YES NO; If no, how was it turned? \_\_\_\_\_

Was your head pointed straight forward? YES NO; If no, what direction was it

turned and by how much? \_\_\_\_\_

What is the year, make and model of the other vehicle?

Year \_\_\_\_\_ make \_\_\_\_\_ model \_\_\_\_\_

Please give your best description of what happened during this accident:

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**THE FOLLOWING INFORMATION IS FROM THE CAR YOU WERE IN DURING THE ACCIDENT.**

Insurance Company \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Insured \_\_\_\_\_ Driver \_\_\_\_\_ Relation \_\_\_\_\_

Policy # \_\_\_\_\_ Claim# \_\_\_\_\_ Claim Adjuster \_\_\_\_\_

**ATTORNEY**

Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

**The Information you've provided on this form is helpful to understanding you accident and injury claim. For proper documentation, patients are required to provide the following items to complete their file:**

- Copies of the following related to this accident:
  - \* Police report and Operator's reports
  - \* Hospital & Doctor's Treatment records
  - \* X-Rays/MRI/CT or other imaging studies and reports
- A copy of the Personal Injury Protection (PIP) form provided by your insurance company
- Your Health Insurance Card (s)
- The Coverage Selection page of your Automobile Insurance
- If you have retained an attorney, we will need the attorney's name, address and phone number

**By signing below, I certify that all the statements above are true and accurate.**

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_