Automobile Accident Questionnaire Good Health Naturally, PLLC

~ Please answer all questions completely ~

DEAR PATIENT: This information is considered confidential. Please be as neat and accurate as possible. Thank you.

| NAME: | DATE: | PATIENT #: |
|---|----------------------------|------------------------------|
| PATIENT'S AUTO INSURANCE CO.: | | |
| POLICY #: | CLAIM #: | |
| NAME OF YOUR INSURANCE ADJUSTER: | | |
| PHONE #: | FAX #: | |
| NAME OF DRIVER OF OTHER VEHICLE : | | PHONE #: |
| OTHER DRIVER INSURANCE CO.: | | |
| INSURANCE ADJUSTER: | | |
| POLICY #: | CLAIM #: | |
| | | |
| Name of driver of vehicle if you were a passenger: | | |
| Other drivers insurance company: | Policy #: | Phone #: |
| Insurance adjuster: | Claim # | : |
| HAVE VOLUDETAINED AN ATTODNEY? | () VEC | () NO |
| HAVE YOU RETAINED AN ATTORNEY? ATTORNEY NAME: | | () NO PHONE #: |
| ATTORNET NAME. | | I HONE # |
| DATE OF ACCIDENT: TI | ME OF ACCIDENT | CITY & STATE |
| | | |
| You were heading: North () | South () East (_ |) West () |
| On (street or highway) | | |
| Other vehicle was heading: North () | South () East (_ |) West () |
| On (street or highway) | | |
| | () Dry () | Icy () Other () |
| Did the police come to the accident scene? Yes | | |
| | () No () | |
| If yes, what hospital? | How | did you get to the hospital? |
| What parts of your body were x-rayed at the hospital | | |
| What treatment was given? | | |
| What was the diagnosis? Was another doctor consulted after your accident? | Voc. () No. () Doc | tor's name: |
| What treatment was given? | 168 () NO () DOC | tor s name |
| What was diagnosis? | | |
| What was diagnosis. | | |
| THE FOLLOWING QUESTIONS PERTAIN TO YO | OII THE PATIENT AND | THE VEHICLE YOU WERE IN: |
| THE POPPONING QUESTIONS PERTIMATO TO | oc, The Tribert hite | THE VEHICLE TOO WERE IN. |
| Where were you seated in the vehicle? | | |
| Were you aware of the approaching collision prior to | impact, or did the impact | catch you by surprise? |
| Did you lose consciousness (black out) upon impact? | | |
| If you did lose consciousness, estimate for how long_ | | |
| How far is the top of the headrest or seatback from th | e top of your head (approx | imately)inches above / below |
| Were you wearing a seatbelt? | Yes () No (_ | _) |
| If "yes" was it a lap seatbelt or a shoulder-lap seatbel | | |
| List the year, make, and model of the vehicle you we | | 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 (_ | _) |
| Please estimate the speed of the vehicle you were in _ | m.p.h. | |

| CONTINUED: QUESTIONS PERTAINING TO THE | PATIENT AND THE VEHICLE: | | |
|---|---|---------------|-----------|
| If the vehicle was moving at the time of impact, was it: | Slowing down? Gaining speed? Traveling at a steady rate of speed? | Yes () No | o () o () |
| Please describe in detail, to the best of your knowledge, | what happened during this accident: | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| What bleeding cuts did you get during this accident? | | | |
| What bruises did you get during this accident? | | | |
| On what part of the auto did the following body parts hi | | | |
| Head hit | | | |
| • Chest hit | | | |
| Right/left shoulder hit | | | |
| • Right/left arm hit | | | |
| • Right/left hip hit | | , | |
| Right/left leg hit | | | |
| Right/left knee hit | | | |
| | | | |
| What is the cost damage to the vehicle you were in? What of the following car parts broke during the accident | nt· | | |
| • Windshield () Front seat back () | Right/left side window () | Steering w | heel () |
| • Other: | raging fert state will do w | Steering W | neer () |
| Was the trunk of your body pointed straight forward at t If "no", which direction was it turned and by how much | | No () | |
| THE FOLLOWING QUESTIONS PERTAIN TO THE | OTHER VEHICLE INVOLVED IN T | HE ACCIDENT: | |
| What is the year make and model of the other webitele | | | |
| What is the year, make, and model of the other vehicle? Year Make | | | |
| Year Make Was the other vehicle moving at the time of the collision | |) | |
| If "yes", what was its approximate speed? m | | / | |
| If the other vehicle was moving at the time of collision, | • | | |
| • Slowing down? | Yes () No (_ |) | |
| • Gaining speed? | Yes () No (_ |) | |
| • Traveling at a steady rate of speed? | Yes () No (|) | |

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