

## Non Auto Accident Questionnaire

Name: \_\_\_\_\_ Sex: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_

Occupation/Empolyer: \_\_\_\_\_ Office Phone #: \_\_\_\_\_

Place of Accident: \_\_\_\_\_

Address of Accident: \_\_\_\_\_

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

Did you Report the Injury (If yes to whom)? \_\_\_\_\_

Where were you taken after the accident? \_\_\_\_\_

What are your symptoms? \_\_\_\_\_

Name of any other doctor consulted since the accident? \_\_\_\_\_

Treatment Received? \_\_\_\_\_ How often treated? \_\_\_\_\_

Did you miss any work? \_\_\_ Yes or \_\_\_ No

Dates you missed work? \_\_\_\_\_

Are your work activities restricted as a result of the accident? \_\_\_ Yes or \_\_\_ No

If so, how? \_\_\_\_\_

Have you been previously injured in a similar manner? \_\_\_ Yes or \_\_\_ No

If so, how? \_\_\_\_\_

Have you ever had any other trauma or accidents? \_\_\_ Yes or \_\_\_ No

If so, please explain? \_\_\_\_\_

Do you favor any part of your body in your daily activites because of this accident?  
\_\_\_ Yes or \_\_\_ No

If so, please explain? \_\_\_\_\_

If so, what part? \_\_\_\_\_

Where you capable of working on an equal basis with your peers before the accident?  
 Yes or  No

Length of present occupation? \_\_\_\_\_

Since the injury, your symptoms are:  Improving  Worsening  Same

Have you retained an attorney?  Yes or  No

If so, give name, address, and phone #: \_\_\_\_\_

Please explain fully how your accident happened:

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