



# Arizona Center for Family and Wellness Care

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## MOTOR VEHICLE COLLISION/PERSONAL INJURY QUESTIONNAIRE

Please answer all questions completely:

1. Your name and address:

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2. Phone Number: \_\_\_\_\_

3. Please describe the collision in your own words:

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4. Where did the collision occur? City/Town: \_\_\_\_\_ State: \_\_\_\_\_

5. Date of collision: \_\_\_\_\_ Time: \_\_\_\_\_ AM PM

6. Were you the:  driver  passenger  pedestrian

7. If passenger, were you in the  front seat  right rear seat  left rear seat

8. What type of vehicle were you in? \_\_\_\_\_

9. What type was the other vehicle? \_\_\_\_\_

10. Did your vehicle strike the other vehicle?  yes  no

11. Was your car struck by the other vehicle?  yes  no

12. What direction was your vehicle going? \_\_\_\_\_

13. What direction was the other vehicle going? \_\_\_\_\_

14. Was the impact from:  the front  the rear  the left side  the right side

15. What was the approximate speed at the time of the impact?

Your vehicle \_\_\_\_\_ mph Other vehicle \_\_\_\_\_ mph

16. What was the weather at the time of the collision?  dry  wet  icy

17. Was your vehicle in:  park  neutral  in gear  moving  stopped

18. Were your brakes being applied?  yes  no

19. Was your vehicle shoved: forward backward sideways
20. Were you shoved: forward whipped backward
21. Did your seat have a head restraint (headrest?) yes no
22. If yes, what was the position low midposition high
23. Did your head ride over the headrest? yes no
24. Did your hat/glasses end up in the back seat or rear window? yes no
25. Did any other part of your body hit the interior of the vehicle? yes no
26. If yes, please specify: seatbelt restraints steering wheel dashboard  
windshield side door side window other \_\_\_\_\_
27. Which part of your body? chest head chin face R L knee  
R L shoulder R L hand other \_\_\_\_\_
28. Were you holding on to the steering wheel? yes no
29. Did you brace your arms against the dash? yes no
30. Did you brace your legs against the floorboard? yes no
31. Was your ankle turned? yes no
32. Did the vehicle go into a spin or roll as a result of the impact? yes no
33. If yes, explain: \_\_\_\_\_
34. How much damage was there to the outside of the vehicle? none some a lot
35. How much damage was there to the inside of the vehicle? none some a lot
36. At the point of impact, where did you experience pain? Be specific:  
\_\_\_\_\_  
\_\_\_\_\_
37. Immediately after the accident were you: conscious dazed unconscious
38. If you lost consciousness, how long? \_\_\_\_\_
39. Were you wearing a seat belt? yes no
40. Did the belt have a shoulder harness? yes no
41. If yes, did it contribute to the pain you are experiencing? yes no
42. At the time of impact were you: looking straight ahead looking to the right  
looking to the left looking down looking up
43. Did the seat break as a result of the impact? yes no
44. Were you braced for the impact? yes no

45. Were you surprised by the impact? yes no

46. Did you go to the hospital? yes no

47. If yes, when? right after the accident next day other \_\_\_\_\_

48. If yes, how did you get there? ambulance other: \_\_\_\_\_

49. If by ambulance, did the ambulance attendants place you in a: neck brace

back brace other \_\_\_\_\_

50. Any medication or medical supplies given? \_\_\_\_\_

51. Did you have x-rays taken at the hospital? yes no

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

Name of hospital \_\_\_\_\_

Name of doctor \_\_\_\_\_

Diagnosis \_\_\_\_\_

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

52. Have you had any similar problems before? yes no

53. If yes, explain: \_\_\_\_\_

54. Are you diabetic? yes no

55. Do you have high blood pressure? yes no

56. Do you have low blood pressure? yes no

57. Do you have arthritis or degenerative joint disease? yes no

58. What type of work do you do? \_\_\_\_\_

59. What are your job requirements? \_\_\_\_\_

60. Have you lost any days of work from this injury? yes no

61. If yes, give dates: \_\_\_\_\_

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

Witness \_\_\_\_\_ Date \_\_\_\_\_

Print Name \_\_\_\_\_

**PERSONAL INJURY INSURANCE COVERAGE**

Date \_\_\_\_\_ Spoke With \_\_\_\_\_ Number \_\_\_\_\_

Patient Name \_\_\_\_\_

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

Address \_\_\_\_\_

Phone Number \_\_\_\_\_

Insured Name \_\_\_\_\_

Date of Accident \_\_\_\_\_

Claim Number \_\_\_\_\_

Policy Number \_\_\_\_\_

Has the accident been reported? yes no

Name of adjuster handling claim \_\_\_\_\_

Will company accept assignment of benefits? yes no

If not, will they make checks payable to patient and our office? yes no

Limits: How much? \$\_\_\_\_\_ What's left? \_\_\_\_\_

**GROUP HEALTH INSURANCE**

Medical benefits under auto insurance? yes no

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

Address \_\_\_\_\_

Phone Number \_\_\_\_\_

Insured Name \_\_\_\_\_

Agent \_\_\_\_\_ Policy# \_\_\_\_\_ Phone \_\_\_\_\_

Name and address of other party or parties involved in collision:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**ATTORNEY INFORMATION**

Date \_\_\_\_\_ Spoke With \_\_\_\_\_ Number \_\_\_\_\_

Patient Name \_\_\_\_\_

Attorney Name \_\_\_\_\_

Address \_\_\_\_\_

Phone Number \_\_\_\_\_

Does attorney need copies of bills? yes no

In the event of settlement, will they protect any unpaid balance? yes no

Do they have PIP? yes no Do we file? yes no

Do they have insurance? yes no Do we file? yes no

Can we file liability? yes no