Bonsall Chiropractic Motor Vehicle Accident Questionnaire

Patient #: _____

Name: _____ Phone: ( ) _____ Cell:( ) _____

Address: _____ City: _____ State: _____ Zip: _____

Age: _____ Birthdate: _____ Sex: _____ S/S #: _____

Employer's Name: _____ Employer's Address: _____

Your Insurance Co.: _____ Policy #: _____ Agent's Name: _____

Driver's License #: _____

Name on Policy (if other than self): _____ Policy #: _____

Responsible Party's Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Policy Holder's Name: _____ Policy #: _____

ATTORNEY:

Name: _____ Phone: ( ) _____

Address: _____ City: _____ State: _____ Zip: _____

Were there any witnesses? ☐ Yes ☐ No Name(s): _____

NATURE OF ACCIDENT:

1, Date of Accident: _____ Time of Day: _____

2. Were you: ☐ Driver ☐ Passenger ☐ Front Seat ☐ Back Seat

3. Number of people in your vehicle?: _____ Were you wearing seat belts?: _____

4. What direction were you headed?: ☐ North ☐ East ☐ South ☐ West
   on (name of street): _____

5. What direction was the other vehicle headed?: ☐ North ☐ East ☐ South ☐ West
   on (name of street): _____

6. Were you struck from: ☐ Behind ☐ Front ☐ Left Side ☐ Right Side

7. Approximate speed of your car: _____ mph Other Car: _____ mph

8. Were you knocked unconscious?: ☐ Yes ☐ No If yes, for how long?: _____

9. Were police notified?: ☐ Yes ☐ No

10. In your own words, please describe accident: _____

_____

_____

_____

11. Did you have any physical complaints BEFORE THE ACCIDENT?: ☐ Yes ☐ No If yes, please describe in detail:

_____

_____

_____

12. Please describe how you felt:
    a. DURING the accident: _____
    b. IMMEDIATELY AFTER the accident: _____
    c. LATER THAT DAY: _____
    d. THE NEXT DAY: _____