

# Automobile Injury Questionnaire

Le Bel Chiropractic, LLC

2141 Boston Road  
Wilbraham, Mass. 01095

Name: \_\_\_\_\_

Today's Date: \_\_\_/\_\_\_/\_\_\_

## Accident Details:

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

Accident Location: Street(s) or Route# \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

The Driver:  Self  Other (who?): \_\_\_\_\_

If "Other", what is your relationship to the person driving the car?

The Driver is my:  Spouse  Friend  Parent  Co-Worker

Other, Describe: \_\_\_\_\_

## Where were you sitting in the vehicle?

Front Seat  2nd row or Back seat  Third row seat

Left side  Middle  Right  Other \_\_\_\_\_

## Safety Equipment Used:

Seat Belt:  None  Shoulder-lap  Lap only  Shoulder only

Air Bag:  Not Available  Not Deployed  Deployed - Front/Side

Your Vehicle: Year: \_\_\_\_\_ Make: \_\_\_\_\_ Model: \_\_\_\_\_

Other Vehicle: Year: \_\_\_\_\_ Make: \_\_\_\_\_ Model: \_\_\_\_\_

## How The Accident Occurred:

Prior to the impact, how fast was your car traveling? About \_\_\_\_\_ MPH

My speed was:  Steady  Increasing  Decreasing  Stopped

Describe how the accident happened:

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

## At the Time of Impact Did You:

Expect the impact?  Yes  No

Lose consciousness?  Yes  No

Hit anything in the vehicle?  Yes  No

Your head was facing:  Forward  Left  Right  Other: \_\_\_\_\_

Your body position at impact: \_\_\_\_\_

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

Phone: 413-271-1020 Fax: 413-271-1023

E-Mail: machiro@aol.com

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Signature: \_\_\_\_\_

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

Name: \_\_\_\_\_

Today's Date: \_\_\_/\_\_\_/\_\_\_

## Reporting Details

Were the Police at the Scene?  Yes  No

Was a report file by the Police?  Yes  No

Have you filed an accident report?  Yes  No

If yes, when did you file the report \_\_\_/\_\_\_/\_\_\_

Have you filed a report and claim with your insurance company?

Yes  No

If yes, when did you file the report \_\_\_/\_\_\_/\_\_\_

Your Insurance Company: \_\_\_\_\_

Policy #: \_\_\_\_\_ Ins. Claim #: \_\_\_\_\_

Claims Adjuster's Name: \_\_\_\_\_

## Previous Treatment

Were you treated at the Hospital?  Yes  No

If yes, when did you go to the Hospital? \_\_\_/\_\_\_/\_\_\_

How did you get to the Hospital?

Ambulance  Drove self  Driven by someone else

What was done at the hospital?

Examination  X-rays  Medication prescribed

Other (describe) \_\_\_\_\_

Have you seen a healthcare provider outside of a hospital?  Yes  No

If yes, Who? \_\_\_\_\_ When? \_\_\_/\_\_\_/\_\_\_

What was done? \_\_\_\_\_

**The information you've provided on this form is helpful to understanding your 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

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## **Automobile Injury Questionnaire**

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- If you have retained an attorney, we will need the attorney's name, address and phone number.

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