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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E-Mail: machiro@aol.com

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