

Automobile Injury Questionnaire

Perrault Chiropractic Offices, Inc.
76 Woodland Street, Methuen, MA 01844

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.

Signature: _____

Date: __/__/____

Phone: 978-686-7791 Fax: 978-975-0468

E-Mail: PerraultChiro@comcast.net

Automobile Injury Questionnaire

Perrault Chiropractic Offices, Inc.
76 Woodland Street, Methuen, MA 01844

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

Phone: 978-686-7791 Fax: 978-975-0468

E-Mail: PerraultChiro@comcast.net