

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

DOB: \_\_\_\_\_

### Auto Accident Questionnaire

1. Please describe your position in the car. ( ex. were you the driver?) \_\_\_\_\_

2. Were you wearing your seatbelt? \_\_\_\_\_

3. Describe what happened in the accident \_\_\_\_\_

4. What road were you on? \_\_\_\_\_

5. What was the estimated speed of the vehicles? \_\_\_\_\_

6. Was your vehicle totaled or what was the damage? \_\_\_\_\_

7. What hurts you? \_\_\_\_\_

8. What arm positions make your pain worse?: \_\_\_\_\_

9. Please list any activities/hobbies outside of work that you are unable to do because of your pain or that make your pain worse (ex: yard work) :

Signature \_\_\_\_\_

Date: