AUTO INJURY QUESTIONNAIRE

Appt Date: Apt. Time: Attorney: Referred by:

YOUR INFORMATION:

Name: ____________________
Address: ____________________
Telephone: Home: __________ Work: __________ Cell: __________
Date of Injury: __________ Location of Accident: __________

Employer's Name: __________ Phone: __________
Employer's Address: ____________________
Hourly Wage: __________ Avg hours per week: __________ Contact Name: __________

Insurance Co: __________ Address: __________
Phone No: __________ Claim No: __________

OTHER DRIVER'S INFORMATION:

Name: ____________________
Address: ____________________
Telephone: Home: __________

Insurance Co: __________ Address: __________
Phone No: __________ Claim No: __________

VEHICLE INFORMATION:

Your Vehicle: Make: __________ Model: __________ Year: __________
Body Type: (circle) ☐ 2 door ☐ 4 door ☐ SUV ☐ Pick-Up ☐ Van Other: __________
Was there visible damage to your car? ☐ yes ☐ no
If yes, describe: ____________________
Do you know the repair estimate? ☐ yes ☐ no If yes, amount: $ __________

Other Vehicle: Make: __________ Model: __________ Year: __________
Body Type: (circle) ☐ 2 door ☐ 4 door ☐ SUV ☐ Pick-Up ☐ Van Other: __________
Was there visible damage to the other car? ☐ yes ☐ no
If yes, describe: ____________________
Do you know the repair estimate? ☐ yes ☐ no If yes, amount: $ __________

ACCIDENT INFORMATION:

You were the: ☐ Driver ☐ Passenger If passenger, where seated? __________
Time of day: ____:____ ☐ Day ☐ Night ☐ Sunrise/Dawn ☐ Sunset/Dusk
Weather: ☐ wet ☐ dry ☐ rain ☐ snow ☐ ice Other: __________
Road surface: ☐ dirt ☐ gravel ☐ asphalt ☐ concrete

The Carlson Law Group
12655 SW Center St, Ste 135,
Beaverton OR 97005
Ph: 503-469-1229
Fx: 503-352-8108

AUTO INJURY QUESTIONNAIRE

Road Design: ☐ straight ☐ curved ☐ intersection
Traffic Control Device: ☐ None ☐ Stop Sign ☐ Light Other: ____________
Was an accident report made? ☐ yes ☐ no To what agency? ____________
Were the police on scene? ☐ yes ☐ no Which agency? ____________
Were pictures taken of the vehicle? ☐ Yes ☐ No If yes, who took them: ________
Were you alone in the car? ☐ Yes ☐ No
If no, list all other people in the car: ____________
Are there airbags in the car? ☐ Yes ☐ No
If yes, did the airbags deploy? ☐ Yes ☐ No Were you hit by the airbag? ______
If the airbag hit you, did it injure you? ☐ Yes ☐ No

WITNESSES:

Did any witnesses identify themselves: ☐ Yes ☐ No
If yes, provide their name and contact information: ____________

INJURIES AND TREATMENT:

Were you aware that the collision was about to happen? ☐ Yes ☐ No
Did you have time to brace yourself? ☐ Yes ☐ No
Did your body hit anything inside the vehicle? ☐ seat belt ☐ head rest ☐ rear-view mirror
☐ steering wheel ☐ windshield ☐ door Other:
Did any of the windows break? ☐ Yes ☐ No
When were you first aware you were injured? within ☐ minutes ☐ hours ☐ days ☐ weeks
Where were you injured? ☐ head ☐ face ☐ neck ☐ chest

Shoulder:	Arm:	Leg:	Knee:	Ankle:
☐ Left	☐ Left	☐ Left	☐ Left	☐ Left
☐ Right	☐ Right	☐ Right	☐ Right	☐ Right

Were you treated at the scene by EMT's? ☐ Yes ☐ No
Were you transported to the hospital? ☐ Yes ☐ No How:
Were there any x-rays, MRI's or CT scans done? ☐ Yes ☐ No
Are you still being treated for your injuries? ☐ Yes ☐ No
If not, date you finished treatment:
Do you still have pain, numbness, tingling, etc from injuries? ☐ Yes ☐ No
If yes, describe:
Have you ever injured the hurt part of your body before this accident? ☐ Yes ☐ No
If yes, explain:

EMPLOYMENT INFORMATION:

Were you employed at the time of the accident? ☐ Yes ☐ No
If yes: Employer Name:
Employer Address:

Employer Phone Number:
Did you miss work because of your injuries: ☐ Yes ☐ No
If yes: Pay rate: $ / ☐ hourly ☐ monthly on salary
Average hours worked: / ☐ day ☐ week
Estimated time lost: ☐ hours ☐ days

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