AUTOMOBILE ACCIDENT QUESTIONNAIRE

Patient's Name: ____ Today's Date: __________________

Date of Accident: ______________________________ Time of Accident: ___________am/pm

In your own words, please describe your accounts of the accident:____

____
____
____
____
____
____

Was there anyone else in your vehicle at the time of the accident: ❑Yes ❑No If yes, please list the names & ages of the other passengers: ____

If you have retained an attorney, please provide the following information:

Attorney Name: ____ Phone Number (_____)________________________

Address: _______________________________________ _________________________ __________ ______________
(Street) (City) (State) (Zip)

If you are filing through car insurance, have you called and received a claim number? ❑Yes ❑No

Insurance Company Name: ___________________________________ Claim Number: _____________________________

Representative Name: ________________________________ Phone Number (_______)_________________________

Address: _______________________________________ _________________________ __________ ______________
(Street) (City) (State) (Zip)

THE FOLLOWING QUESTIONS PERTAIN TO YOU AND THE VEHICLE YOU WERE IN:

Vehicle type:
- ❑Car
- ❑Pickup
- ❑Van
- ❑Truck
- ❑Station Wagon
- ❑Bus
- ❑Other_________________

Vehicle size:
- ❑Subcompact
- ❑Full-size
- ❑Compact
- ❑Mini
- ❑Mid-size
- ❑Light
- ❑Heavy
- ❑Other__________________

Collision Type:
- ❑Driver Side Impact
- ❑Passenger Side Impact
- ❑Front Impact
- ❑Rear Impact
- ❑Head On Collision
- ❑Pedestrian Incident

Your position in the vehicle:
- ❑Driver
- ❑Passenger: ❑Front
- ❑Rear: ❑Left ❑Middle ❑Right
- ❑Third Row: ❑Left ❑Middle ❑Right
- ❑Other: _________________________

Speed of your vehicle:
- ❑Stopped
- ❑Moving Moderately
- ❑Parked
- ❑Moving Fast
- ❑Slowing
- ❑Moving at ____MPH
- ❑Moving Slowly

Why Vehicle was slowed/stopped:
- ❑Traffic Signal
- ❑Parking
- ❑Pedestrian
- ❑Traffic
- ❑Stop Sign
- ❑Busy Intersection

THE FOLLOWING QUESTIONS CONCERN THE OTHER VEHICLE INVOLVED IN THE ACCIDENT:

Vehicle type:
- ❑Car
- ❑Van
- ❑Station Wagon
- ❑Other_______________

Vehicle size:
- ❑Pickup
- ❑Subcompact
- ❑Full-size
- ❑Truck
- ❑Compact
- ❑Mini
- ❑Bus
- ❑Mid-size
- ❑Light
- ❑Heavy
- ❑Other__________________

Speed of the other vehicle:
- ❑Moving Moderately
- ❑Moving Fast
- ❑Moving Slowly
- ❑Slowing
- ❑ Moving at approx ____MPH

CONDITIONS AT THE TIME OF THE ACCIDENT:

Time of day:
- ❑Full daylight
- ❑Dawn
- ❑Dusk
- ❑Night

Road Conditions:
- ❑Dry
- ❑Damp
- ❑Wet
- ❑Snow covered
- ❑Ice covered
- ❑Patchy Ice/Snow

Visibility:
- ❑Excellent
- ❑Good
- ❑Fair
- ❑Poor

Visibility compromised by:
- ❑Brightness
- ❑Darkness
- ❑Rain
- ❑Snow
- ❑Fog
- ❑Traffic

THE FOLLOWING QUESTIONS CONCERN THE MOMENT OF IMPACT OF THE ACCIDENT:

Were you...
- ❑Totally unaware that the accident was impending
- ❑Aware that the accident was impending
- ❑Aware that the accident was impending and braced for it

Restraints: (check all that apply)
- ❑Seat belt
- ❑Shoulder harness
- ❑No restraints

Was the air bag deployed?
- ❑Car not equipped with air bag
- ❑Air bag deployed
- ❑Air bag not deployed

If you were the driver of the vehicle, was your foot on the brake pedal? ❑Yes ❑No ❑Knocked off by impact

What position was YOUR headrest in?
- ❑High position
- ❑Middle position
- ❑ Low position

Position of YOUR head at time of impact?
- ❑Facing straight ahead
- ❑Tilted forward
- ❑Rotated to the left
- ❑Rotated to the right

Was your head thrown...?
- ❑Backward and then forward
- ❑Forward then backward
- ❑To the left ❑To the left then the right
- ❑To the right ❑To the right, then the left

Position of Your body at time of impact?
- ❑Straight
- ❑Tilted forward
- ❑Rotated to the left
- ❑Rotated to the right

Was your body thrown...?
- ❑Backward and then forward ❑To the left ❑To the left then the right
- ❑Forward then backward ❑To the right ❑To the right, then the left
- ❑Across the vehicle ❑Under the vehicle ❑Outside the vehicle

Damage to vehicle YOU were in:
- ❑Incurred minimal damage
- ❑Incurred moderate damage
- ❑Incurred severe damage
- ❑Was totaled
- ❑Not known

Citations:
- ❑None issued
- ❑Yourself
- ❑Driver of vehicle patient was a passenger of
- ❑Driver of other vehicle
- ❑Not sure

Was there a Police Report:
❑Yes ❑No

If yes, do you have a copy of the Police Report:
❑Yes ❑No

AS A RESULT OF THE FORCE OF THE COLLISION, WHICH OBJECTS IN THE VEHICLE DID YOUR BODY STRIKE?

Head
- ❑Steering wheel ❑Right door
- ❑Dashboard ❑Left window
- ❑Windshield ❑Right window
- ❑Armrest ❑Console
- ❑Headrest ❑Gear shift
- ❑Rear view mirror ❑Front seat
- ❑Left door ❑Backseat

Left Arm
- ❑Steering wheel ❑Right door
- ❑Dashboard ❑Left window
- ❑Windshield ❑Right window
- ❑Armrest ❑Console
- ❑Headrest ❑Gear shift
- ❑Rear view mirror ❑Front seat
- ❑Left door ❑Backseat

Right Arm
- ❑Steering wheel ❑Right door
- ❑Dashboard ❑Left window
- ❑Windshield ❑Right window
- ❑Armrest ❑Console
- ❑Headrest ❑Gear shift
- ❑Rear view mirror ❑Front seat
- ❑Left door ❑Backseat

Torso
- ❑Steering wheel ❑Right door
- ❑Dashboard ❑Left window
- ❑Windshield ❑Right window
- ❑Armrest ❑Console
- ❑Headrest ❑Gear shift
- ❑Rear view mirror ❑Front seat
- ❑Left door ❑Backseat

Left Leg
- ❑Steering wheel ❑Right door
- ❑Dashboard ❑Left window
- ❑Windshield ❑Right window
- ❑Armrest ❑Console
- ❑Headrest ❑Gear shift
- ❑Rear view mirror ❑Front seat
- ❑Left door ❑Backseat

Right Leg
- ❑Steering wheel ❑Right door
- ❑Dashboard ❑Left window
- ❑Windshield ❑Right window
- ❑Armrest ❑Console
- ❑Headrest ❑Gear shift
- ❑Rear view mirror ❑Front seat
- ❑Left door ❑Backseat

THE FOLLOWING QUESTIONS CONCERN THE TIME PERIOD IMMEDIATELY FOLLOWING THE ACCIDENT:

Did you lose consciousness?
- ❑Yes
- ❑No

Were you able to walk unaided?
- ❑Yes
- ❑No

Immediately following the accident, did you feel...?
- ❑Dizzy ❑Weak
- ❑Dazed ❑Nervous
- ❑Disoriented ❑Nauseated

Where did you go...?
- ❑Drove home ❑Drove to work ❑Was driven to school
- ❑Drove to school ❑Was driven to work ❑Was driven to hospital
- ❑Drove to hospital ❑Was driven home ❑Taken to hospital via ambulance

Next day discomfort...?

❑increased ❑decreased ❑same

Did your major complaints exist before the accident?

❑Yes ❑ No

Please mark the boxes below that apply to you as described by the titles in the columns listed below:

Body Location	What areas did you IMMEDIATELY feel pain?	In what areas did you experience lacerations (cuts)?	If you went to the hospital, what areas were x-rayed?	Where did you experience pain on the day FOLLOWING the accident?
Head				
Neck				
Upper Back				
Mid Back				
Ribs				
Chest				
Abdomen				
Low Back				
Pelvis				
Shoulder	❑Left ❑Right	❑Left ❑Right	❑Left ❑Right	❑Left ❑Right
Arm	❑Left ❑Right	❑Left ❑Right	❑Left ❑Right	❑Left ❑Right
Elbow	❑Left ❑Right	❑Left ❑Right	❑Left ❑Right	❑Left ❑Right
Wrist	❑Left ❑Right	❑Left ❑Right	❑Left ❑Right	❑Left ❑Right
Hand	❑Left ❑Right	❑Left ❑Right	❑Left ❑Right	❑Left ❑Right
Fingers	❑Left ❑Right	❑Left ❑Right	❑Left ❑Right	❑Left ❑Right
Buttocks	❑Left ❑Right	❑Left ❑Right	❑Left ❑Right	❑Left ❑Right
Hips	❑Left ❑Right	❑Left ❑Right	❑Left ❑Right	❑Left ❑Right
Thigh	❑Left ❑Right	❑Left ❑Right	❑Left ❑Right	❑Left ❑Right
Knee	❑Left ❑Right	❑Left ❑Right	❑Left ❑Right	❑Left ❑Right
Calf	❑Left ❑Right	❑Left ❑Right	❑Left ❑Right	❑Left ❑Right
Ankle	❑Left ❑Right	❑Left ❑Right	❑Left ❑Right	❑Left ❑Right
Foot	❑Left ❑Right	❑Left ❑Right	❑Left ❑Right	❑Left ❑Right
Toes	❑Left ❑Right	❑Left ❑Right	❑Left ❑Right	❑Left ❑Right

Patient's Signature:____ Date:_______________

Office Use Only: