



## **AUTOMOBILE ACCIDENT QUESTIONNAIRE**

Today's Date: \_\_\_\_\_

Patient's Name: \_\_\_\_\_  
(Last name) (First name) (M.I.)

Date of Accident: \_\_\_\_\_

### **Please describe vehicle you were in during the accident.**

#### **Vehicle type:**

- Car                       Pickup  
 Van                         Truck  
 SUV                        Bus  
 Other \_\_\_\_\_

#### **Vehicle size:**

- Subcompact    Full-size  
 Compact        Mini  
 Mid-size         Light  
 Heavy             Other \_\_\_\_\_

#### **Your position in the vehicle:**

- Driver  
 Passenger  
  
 Other \_\_\_\_\_

#### **If Passenger, where were you seated:**

- Front Passenger  
 Rear Passenger:  
 Middle    Left    Right  
 Third Seat (rear)

#### **Speed of your vehicle:**

- Stopped     Moving Moderately  
 Parked      Moving Fast  
 Slowing     Moving at approx. \_\_\_\_\_MPH

Moving Slowly

#### **Why was the vehicle slowed or stopped:**

- Traffic Signal     Parking  
 Pedestrian        Traffic  
 Stop Sign  
 Busy Intersection

#### **Collision Type:**

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

**Please describe the other vehicle involved in the accident.**

**Vehicle type:**

- Car
- Van
- SUV
- Other \_\_\_\_\_
- Pickup
- Truck
- Bus

**Vehicle size:**

- Subcompact
- Compact
- Mid-size
- Heavy
- Full-size
- Mini
- Light
- Other \_\_\_\_\_

**What were the conditions at the time of the accident?**

**Time of day:**

- Full daylight
- Dusk
- Night

**Road Conditions:**

- Dry
- Damp
- Wet
- Snow-covered
- Ice-covered
- Patchy Ice/Snow

**Visibility:**

- Excellent
- Good
- Fair
- Poor

**Visibility Compromised**

- Brightness
- Darkness
- Rain
- Snowing
- Fog
- Traffic

**Please describe the moment of impact during 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:**

- Seat belt
- Shoulder harness
- No restraints

**Was your foot on the brake pedal?**  Yes  No  Knocked off by impact

**Was the air bag deployed?**

- Car not equipped with air bag
- Air bag deployed
- Air bag not deployed

**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 right
- To the right
- To the right then left

**Position of Your body at time of impact?**

- Straight
- Tilted forward
- Rotated to the left

**Was your body thrown...?**

- Backward and then forward
- Forward then backward
- To the left

Rotated to the right

- To the left then the right
- To the right
- To the right, then the left
- Across the vehicle
- Outside the vehicle
- Under 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

**As a result of the force of the collision,  
against what part of the vehicle did your body strike?**

**Head**

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

**Left Arm**

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

**Right Arm**

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

**Torso**

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

**Left Leg**

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

**Right Leg**

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

**Explain your condition and the events that directly followed the accident?**

**Did you lose consciousness? Immediately following the accident, did you feel?**

- Yes
- No

- Dizzy
- Dazed
- Disoriented

- Weak
- Nervous
- Nauseated

**Were you able to walk unaided?**

- Yes
- No

**Where did you go...?**

- Drove home
- Was driven home
- Drove to hospital
- Was driven to hospital
- Taken to hospital via ambulance
- Drove to work
- Was driven to work
- Drove to school
- Was driven to school

**Hospital Name:** \_\_\_\_\_

**Date of hospital visit:**     /     /     \_\_\_\_\_

**Were you admitted:** Yes/ No

**Next day discomfort?**

- increased
- decreased

**Did your major complaints exist before the accident?**

- remained the same
- No
- Yes

**In what areas did you IMMEDIATELY feel pain?**

- |                                     |                                 |                               |                                |       |                               |                                |
|-------------------------------------|---------------------------------|-------------------------------|--------------------------------|-------|-------------------------------|--------------------------------|
| <input type="checkbox"/> Head       | Shoulder                        | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Hip   | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Neck       | Arm                             | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Thigh | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Upper back | Elbow                           | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Knee  | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Mid back   | Wrist                           | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Calf  | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Ribs       | Hand                            | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Ankle | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Chest      | Fingers                         | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Foot  | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Abdomen    | Buttock                         | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Toes  | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Low Back   | <input type="checkbox"/> Pelvis |                               |                                |       |                               |                                |

**Did you feel any numbness or tingling?**

- Yes     If so, describe where: \_\_\_\_\_
- No

**In what areas did you experience lacerations (cuts)?**

- |                                     |                                 |                               |                                |       |                               |                                |
|-------------------------------------|---------------------------------|-------------------------------|--------------------------------|-------|-------------------------------|--------------------------------|
| <input type="checkbox"/> Head       | Shoulder                        | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Hip   | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Neck       | Arm                             | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Thigh | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Upper back | Elbow                           | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Knee  | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Mid back   | Wrist                           | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Calf  | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Ribs       | Hand                            | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Ankle | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Chest      | Finger                          | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Foot  | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Abdomen    | Buttock                         | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Toes  | <input type="checkbox"/> Left |                                |
| <input type="checkbox"/> Low Back   | <input type="checkbox"/> Pelvis |                               |                                |       |                               |                                |

**At the hospital, what areas were x-rayed?**

- |                                     |          |                               |                                |       |                               |                                |
|-------------------------------------|----------|-------------------------------|--------------------------------|-------|-------------------------------|--------------------------------|
| <input type="checkbox"/> Head       | Shoulder | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Hip   | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Neck       | Arm      | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Thigh | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Upper back | Elbow    | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Knee  | <input type="checkbox"/> Left | <input type="checkbox"/> Right |

- |                                   |                                 |  |       |  |
|-----------------------------------|---------------------------------|--|-------|--|
| <input type="checkbox"/> Mid back | Wrist                           | <input type="checkbox"/> Left <input type="checkbox"/> Right | Calf  | <input type="checkbox"/> Left <input type="checkbox"/> Right |
| <input type="checkbox"/> Ribs     | Hand                            | <input type="checkbox"/> Left <input type="checkbox"/> Right | Ankle | <input type="checkbox"/> Left <input type="checkbox"/> Right |
| <input type="checkbox"/> Chest    | Fingers                         | <input type="checkbox"/> Left <input type="checkbox"/> Right | Foot  | <input type="checkbox"/> Left <input type="checkbox"/> Right |
| <input type="checkbox"/> Abdomen  | Buttock                         | <input type="checkbox"/> Left <input type="checkbox"/> Right | Toes  | <input type="checkbox"/> Left <input type="checkbox"/> Right |
| <input type="checkbox"/> Low Back | <input type="checkbox"/> Pelvis |  |       |  |

**Where did you experience pain on the day FOLLOWING the accident?**

- |                                     |                                 |  |       |  |
|-------------------------------------|---------------------------------|--|-------|--|
| <input type="checkbox"/> Head       | Shoulder                        | <input type="checkbox"/> Left <input type="checkbox"/> Right | Hip   | <input type="checkbox"/> Left <input type="checkbox"/> Right |
| <input type="checkbox"/> Neck       | Arm                             | <input type="checkbox"/> Left <input type="checkbox"/> Right | Thigh | <input type="checkbox"/> Left <input type="checkbox"/> Right |
| <input type="checkbox"/> Upper back | Elbow                           | <input type="checkbox"/> Left <input type="checkbox"/> Right | Knee  | <input type="checkbox"/> Left <input type="checkbox"/> Right |
| <input type="checkbox"/> Mid back   | Wrist                           | <input type="checkbox"/> Left <input type="checkbox"/> Right | Calf  | <input type="checkbox"/> Left <input type="checkbox"/> Right |
| <input type="checkbox"/> Ribs       | Hand                            | <input type="checkbox"/> Left <input type="checkbox"/> Right | Ankle | <input type="checkbox"/> Left <input type="checkbox"/> Right |
| <input type="checkbox"/> Chest      | Finger                          | <input type="checkbox"/> Left <input type="checkbox"/> Right | Foot  | <input type="checkbox"/> Left <input type="checkbox"/> Right |
| <input type="checkbox"/> Abdomen    | Buttock                         | <input type="checkbox"/> Left <input type="checkbox"/> Right | Toes  | <input type="checkbox"/> Left <input type="checkbox"/> Right |
| <input type="checkbox"/> Low Back   | <input type="checkbox"/> Pelvis |  |       |  |

**As result of the accident, did you have to take time off from work or school?**

- Yes      If so, give dates  
missed: \_\_\_\_\_
- No

Do you have an attorney: Yes/ No

Attorney's information: Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 Phone #: \_\_\_\_\_

Insurance information: Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 Phone #: \_\_\_\_\_  
 Claim #: \_\_\_\_\_  
 Contact Person: \_\_\_\_\_

**Patient's Signature:** \_\_\_\_\_

**Today's Date:** \_\_\_\_\_