AUTOMOBILE ACCIDENT QUESTIONNAIRE

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Today's Date: ___________________________________

Patient's Name: ____ Date of Accident: _____________________

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

Vehicle type:

☐Car	☐Pickup
☐Van	☐Truck
☐4X4	☐Bus
☐Other	

Your position in the vehicle:
☐Driver
☐Front Passenger
☐Rear Passenger
☐Third seat (rear)
☐Other: ____________________

Speed of the vehicle:
☐Stopped ☐Moving moderately
☐Parked ☐Moving fast
☐Slowing ☐Moving slowly

Why vehicle was slowed or stopped:
☐Traffic signal ☐Pedestrian
☐Parking ☐Stop sign
☐Traffic ☐Busy Intersection

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

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

Vehicle type:

☐Car	☐Pickup
☐Van	☐Truck
☐4X4	☐Bus
☐Other	

Road conditions at the time of the accident:
☐Dry
☐Damp
☐Wet
☐Snow/Ice Covered
☐Patchy Ice/Snow

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

If you were the driver of the vehicle, 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 and then backward
- ☐ To the left
- ☐ To the right
- ☐ To the left, then to the right
- ☐ To the right, then to the left

Position of YOUR body at the time of impact:
- ☐ Straight
- ☐ Tilted forward
- ☐ Rotated to the left
- ☐ Rotated to the right

Was your body thrown:
- ☐ Backward and then forward
- ☐ Forward and then backward
- ☐ To the left
- ☐ To the right
- ☐ To the left, then to the right
- ☐ To the right, then to the left

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, WHICH OBJECTS IN 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

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 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

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

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

Next day discomfort:

☐ Increased ☐ Decreased ☐ Same

Did your major complaints exist before the accident? ☐ Yes ☐ No

In what areas did you feel pain IMMEDIATELY?

☐ Head	☐ Shoulder	☐ Left	☐ Right	☐ Hip	☐ Left	☐ Right
☐ Neck	☐ Arm	☐ Left	☐ Right	☐ Thigh	☐ Left	☐ Right
☐ Upper Back	☐ Elbow	☐ Left	☐ Right	☐ Knee	☐ Left	☐ Right
☐ Mid Back	☐ Wrist	☐ Left	☐ Right	☐ Calf	☐ Left	☐ Right
☐ Low Back	☐ Hand	☐ Left	☐ Right	☐ Ankle	☐ Left	☐ Right
☐ Chest	☐ Fingers	☐ Left	☐ Right	☐ Foot	☐ Left	☐ Right
☐ Abdomen	☐ Ribs	☐ Left	☐ Right	☐ Toes	☐ Left	☐ Right

In what areas did you experience lacerations (cuts)?

☐ Head	☐ Shoulder	☐ Left	☐ Right	☐ Hip	☐ Left	☐ Right
☐ Neck	☐ Arm	☐ Left	☐ Right	☐ Thigh	☐ Left	☐ Right
☐ Upper Back	☐ Elbow	☐ Left	☐ Right	☐ Knee	☐ Left	☐ Right
☐ Mid Back	☐ Wrist	☐ Left	☐ Right	☐ Calf	☐ Left	☐ Right
☐ Low Back	☐ Hand	☐ Left	☐ Right	☐ Ankle	☐ Left	☐ Right
☐ Chest	☐ Fingers	☐ Left	☐ Right	☐ Foot	☐ Left	☐ Right
☐ Abdomen	☐ Ribs	☐ Left	☐ Right	☐ Toes	☐ Left	☐ Right

At the hospital, what areas were X-rayed?

☐ Head	☐ Shoulder	☐ Left	☐ Right	☐ Hip	☐ Left	☐ Right
☐ Neck	☐ Arm	☐ Left	☐ Right	☐ Thigh	☐ Left	☐ Right
☐ Upper Back	☐ Elbow	☐ Left	☐ Right	☐ Knee	☐ Left	☐ Right
☐ Mid Back	☐ Wrist	☐ Left	☐ Right	☐ Calf	☐ Left	☐ Right
☐ Low Back	☐ Hand	☐ Left	☐ Right	☐ Ankle	☐ Left	☐ Right
☐ Chest	☐ Fingers	☐ Left	☐ Right	☐ Foot	☐ Left	☐ Right
☐ Abdomen	☐ Ribs	☐ Left	☐ Right	☐ Toes	☐ Left	☐ Right

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

☐ Head	☐ Shoulder	☐ Left	☐ Right	☐ Hip	☐ Left	☐ Right
☐ Neck	☐ Arm	☐ Left	☐ Right	☐ Thigh	☐ Left	☐ Right
☐ Upper Back	☐ Elbow	☐ Left	☐ Right	☐ Knee	☐ Left	☐ Right
☐ Mid Back	☐ Wrist	☐ Left	☐ Right	☐ Calf	☐ Left	☐ Right
☐ Low Back	☐ Hand	☐ Left	☐ Right	☐ Ankle	☐ Left	☐ Right
☐ Chest	☐ Fingers	☐ Left	☐ Right	☐ Foot	☐ Left	☐ Right
☐ Abdomen	☐ Ribs	☐ Left	☐ Right	☐ Toes	☐ Left	☐ Right

Patient's Signature: ______________________________ **Date:** ________________