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AUTOMOBILE ACCIDENT QUESTIONAIRE

PATIENT INFORMATION

Patient Name:____Date: _________________

1. What was the date of the accident?____________What time did the accident occur? ___________________
2. Describe the accident in your own words?____
   ____

IMPACT/ACCIDENT SITE

1. How many vehicles were involved in the accident?____
2. What was the estimated damage to the vehicle you were in?____
3. What city and state did the accident occur in?____
4. What street or intersection were you on when the accident occurred?_________________________________
5. What direction were you traveling in?____
6. What type of impact was the auto accident?____
7. Did your vehicle hit anything after the accident? ☐ no ☐ yes
   explain____
8. Where were you sitting in the vehicle during the accident?_________________ _________________________
9. Did you know the accident was coming?____
10. At the time of the impact how fast was your vehicle moving?_______________________________________
11. At the time of impact, how fast was the other vehicle moving?______________________________________
12. How many passangers were in your vehicle?____
13. During and after the crash what happened to you vehicle? (check all that apply)
    ☐ kept going straight ☐ spun around
    ☐ kept going straight hitting a care in front ☐ spun around and hit a stationary object
    ☐ was hit by another vehicle ☐ hit a stationary object

VEHICLE

1. What type of vehicle were you in?____
2. What type of vehicle impacted yours?____
3. .What kind of headrest was in your vehicle?
   ☐ movable fixed headrest ☐ non-moveable fixed headrest ☐ no headrest
4. Where was the headrest positioned on your head?____
5. Did you have your seatbelt on during the accident? ☐ no ☐ yes
6. Did you slide out of your seatbelt during the accident? ☐ no ☐ yes
7. What was damaged in your vehicle? (check all that applies)

☐ windshield	☐ side window	☐ trunk	☐mirror
☐steering wheel	☐ rear window	☐ front left door	☐knee bolster
☐ dashboard	☐ rear bumper	☐ front right door	☐ back right door
☐ seat frame	☐ front bumper	☐ back left door	☐ completely totaled

8. Choose the items that dented inward
   ☐ floorboards ☐ side doors ☐dashboard
9. Choose the doors that would not open as a result of the accident
   ☐ front left ☐ front right ☐ rear left ☐ rear right

POLICE

1. Did the police come to the accident site? ☐ no ☐ yes
2. Where there any witness? ☐ no ☐ yes
3. Was a police report filed? ☐ no ☐ yes
4. Was a traffic violation issued? ☐ no ☐ yes
   If so to whom?____

PATIENT CONDITION

1. Did you lose consciousness during the accident? ☐ no ☐ yes
2. How was you head positioned during the accident?____
3. How was your torso positioned during the accident?____

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4. How were your hands positioned during the accident?____
5. Did your face hit anything during the accident?
   - no - yes explain____
6. Did your head hit anything during the accident?
   - no - yes explain____
7. Did your shoulders hit anything during the accident?
   - no - yes explain____
8. Did your neck hit anything during the accident?
   - no - yes explain____
9. Did your chest hit anything during the accident?
   - no - yes explain____
10. Did your hips hit anything during the accident?
   - no - yes explain____
11. Did your knees hit anything during the accident?
   - no - yes explain____

SYMPTOMS

1. Have you been able to work since the injury? - yes - no How many work days have you missed?______
2. Prior to the accident were you able to work on an equal basis with others your age? - yes - no
3. If you have had any of the following symptoms since you injury please check:

Arm/Shoulder Pain	Feet/Toe numbness	Neck Pain
Back Pain	Hand/Finger numbness	Neck Stiffness
Back Stiffness	Headaches	Shortness of Breath
Chest Pain	Irritability	Sleep Difficulty
Dizziness	Jaw Problems	Stomach Upset
Leg Pain	Ear Buzzing	Tension
Memory Loss	Ear Ringing	Vision Blurred
Fatigue	Nausea	

4. Is this condition getting progressively worse? - yes - no - unknown
5. Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____
6. Type of pain:

sharp	dull	throbbing	numbness
aching	shooting	burning	tingling
cramps	stiffness	swelling	other___________

7. How often do you have this pain?____
8. Is it constant or does it come and go?____
9. Does it interfere with: - Work - Sleep - Daily Routine - Recreation
10. Movement that are painful to perform: - Sitting - Standing - Walking - Bending - Lying Down

TREATMENT

1. Did you go to the hospital? - yes - no if not skip questions 38-43
2. How did you get to the hospital?____
3. What was the name of the hospital?____
4. Were you hospitalized? - no - yes how long?____
5. Circle what you were prescribed in the hospital/emergency room
   - pain medication - muscle relaxers - neck brace - other explain________________________________
6. Did you receive any stitches for any cuts at the hospital - no - yes, where?_____________________
7. Were xrays taken in the hospital? - no - yes which areas were taken?______________________

Patient signature:_______________________________________Date:________________________________