

Automobile Accident Questionnaire

Patient Name: _____

Date: _____

| | |
|---|---|
| Date of Accident: | |
| The Following Questions Pertain To You And The Vehicle You Were In | |
| What was your position in the vehicle? | <input type="checkbox"/> Driver <input type="checkbox"/> Passenger --- Position: <input type="checkbox"/> Left <input type="checkbox"/> Middle <input type="checkbox"/> Right <input type="checkbox"/> Front Passenger <input type="checkbox"/> Rear Passenger <input type="checkbox"/> Third Row (rear) |
| Vehicle size? | <input type="checkbox"/> Subcompact <input type="checkbox"/> Full-size <input type="checkbox"/> Compact <input type="checkbox"/> Mini <input type="checkbox"/> Mid-size <input type="checkbox"/> Light <input type="checkbox"/> Heavy <input type="checkbox"/> Other: _____ |
| Vehicle type? | <input type="checkbox"/> Car <input type="checkbox"/> Van <input type="checkbox"/> Pickup <input type="checkbox"/> Truck <input type="checkbox"/> Station Wagon <input type="checkbox"/> Bus <input type="checkbox"/> SUV <input type="checkbox"/> Other: _____ |
| What was the speed of your vehicle? | <input type="checkbox"/> Stopped <input type="checkbox"/> Parked <input type="checkbox"/> Slowing <input type="checkbox"/> Moving Slowly <input type="checkbox"/> Moving Moderately <input type="checkbox"/> Moving Fast <input type="checkbox"/> Moving at approx _____ MPH |
| Why was your vehicle slowed or stopped? (if applicable) | <input type="checkbox"/> Traffic Signal <input type="checkbox"/> Parking <input type="checkbox"/> Pedestrian <input type="checkbox"/> Traffic <input type="checkbox"/> Stop Sign <input type="checkbox"/> Busy Intersection |
| Collision type? | <input type="checkbox"/> Driver Side Impact <input type="checkbox"/> Passenger Side Impact <input type="checkbox"/> Front Impact <input type="checkbox"/> Head on Collision <input type="checkbox"/> Rear Impact <input type="checkbox"/> Pedestrian Incident |
| The Following Questions Concern The Other Vehicle Involved In The Accident | |
| (If this was a single vehicle accident, skip the next two questions. If this was a multiple vehicle accident, mark all that apply and list details on the last page under other pertinent information.) | |
| Vehicle size? | <input type="checkbox"/> Subcompact <input type="checkbox"/> Full-size <input type="checkbox"/> Compact <input type="checkbox"/> Mini <input type="checkbox"/> Mid-size <input type="checkbox"/> Light <input type="checkbox"/> Heavy <input type="checkbox"/> Other: _____ |
| Vehicle type? | <input type="checkbox"/> Car <input type="checkbox"/> Van <input type="checkbox"/> Pickup <input type="checkbox"/> Truck <input type="checkbox"/> Station Wagon <input type="checkbox"/> Bus <input type="checkbox"/> SUV <input type="checkbox"/> Other: _____ |
| Conditions At The Time Of The Accident | |
| Time of day? | <input type="checkbox"/> Full Daylight <input type="checkbox"/> Dawn <input type="checkbox"/> Dusk <input type="checkbox"/> Night |
| Road conditions? | <input type="checkbox"/> Dry <input type="checkbox"/> Damp <input type="checkbox"/> Wet <input type="checkbox"/> Snow Covered <input type="checkbox"/> Ice Covered <input type="checkbox"/> Patchy Ice/Snow |
| Visibility? | <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor |
| Visibility affected by? | <input type="checkbox"/> Brightness <input type="checkbox"/> Darkness <input type="checkbox"/> Rain <input type="checkbox"/> Snow <input type="checkbox"/> Fog <input type="checkbox"/> Traffic |
| The Following Questions Concern The Moment Of Impact Of The Accident | |
| Were you...? | <input type="checkbox"/> Totally unaware that the accident was impending <input type="checkbox"/> Aware that the accident was impending <input type="checkbox"/> Aware that the accident was impending and braced for it |
| Restraints? | <input type="checkbox"/> Lap belt & shoulder harness <input type="checkbox"/> Shoulder harness only <input type="checkbox"/> Lap belt only <input type="checkbox"/> No restraints |
| Was the air bag deployed? | <input type="checkbox"/> Car not equipped with air bag <input type="checkbox"/> Air bag deployed <input type="checkbox"/> Air bag not deployed |

 Patient's Signature

 Date

Automobile Accident Questionnaire, continued

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|--|---|
| If you were the driver of the vehicle, was your foot on the brake pedal? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Knocked off by impact |
| What position was YOUR headrest in? | <input type="checkbox"/> High position <input type="checkbox"/> Middle position <input type="checkbox"/> Low position |
| Position of YOUR head at time of impact? | <input type="checkbox"/> Facing straight ahead <input type="checkbox"/> Tilted forward <input type="checkbox"/> Rotated to the left <input type="checkbox"/> Rotated to the right |
| Position of YOUR body at time of impact? | <input type="checkbox"/> Straight <input type="checkbox"/> Tilted forward <input type="checkbox"/> Rotated to the left <input type="checkbox"/> Rotated to the right |
| Was your head thrown...? | <input type="checkbox"/> Backward and then forward <input type="checkbox"/> Forward then backward <input type="checkbox"/> To the left <input type="checkbox"/> To the right <input type="checkbox"/> To the left, then the right <input type="checkbox"/> To the right, then the left |
| Was your body thrown...? | <input type="checkbox"/> Backward and then forward <input type="checkbox"/> Forward then backward <input type="checkbox"/> To the left <input type="checkbox"/> To the right <input type="checkbox"/> To the left, then the right <input type="checkbox"/> To the right, then the left <input type="checkbox"/> Across the vehicle <input type="checkbox"/> Outside the vehicle <input type="checkbox"/> Under the vehicle |
| Damage to vehicle YOU were in? | <input type="checkbox"/> Incurred minimal damage <input type="checkbox"/> Incurred moderate damage <input type="checkbox"/> Incurred severe damage <input type="checkbox"/> Was totaled <input type="checkbox"/> Not known |
| Citations? | <input type="checkbox"/> None issued <input type="checkbox"/> Yourself <input type="checkbox"/> Driver of vehicle patient was a passenger of <input type="checkbox"/> Driver of other vehicle <input type="checkbox"/> Not sure |
| As A Result Of The Force Of The Collision, Which Objects In The Vehicle Did Your Body Strike? | |
| Head | <input type="checkbox"/> Steering wheel <input type="checkbox"/> Dashboard <input type="checkbox"/> Windshield <input type="checkbox"/> Armrest <input type="checkbox"/> Headrest <input type="checkbox"/> Rear view mirror <input type="checkbox"/> Left door <input type="checkbox"/> Right door <input type="checkbox"/> Left window <input type="checkbox"/> Right window <input type="checkbox"/> Console <input type="checkbox"/> Gear shift <input type="checkbox"/> Front seat <input type="checkbox"/> Back seat |
| Left Arm | <input type="checkbox"/> Steering wheel <input type="checkbox"/> Dashboard <input type="checkbox"/> Windshield <input type="checkbox"/> Armrest <input type="checkbox"/> Headrest <input type="checkbox"/> Rear view mirror <input type="checkbox"/> Left door <input type="checkbox"/> Right door <input type="checkbox"/> Left window <input type="checkbox"/> Right window <input type="checkbox"/> Console <input type="checkbox"/> Gear shift <input type="checkbox"/> Front seat <input type="checkbox"/> Back seat |
| Right Arm | <input type="checkbox"/> Steering wheel <input type="checkbox"/> Dashboard <input type="checkbox"/> Windshield <input type="checkbox"/> Armrest <input type="checkbox"/> Headrest <input type="checkbox"/> Rear view mirror <input type="checkbox"/> Left door <input type="checkbox"/> Right door <input type="checkbox"/> Left window <input type="checkbox"/> Right window <input type="checkbox"/> Console <input type="checkbox"/> Gear shift <input type="checkbox"/> Front seat <input type="checkbox"/> Back seat |
| Torso | <input type="checkbox"/> Steering wheel <input type="checkbox"/> Dashboard <input type="checkbox"/> Windshield <input type="checkbox"/> Armrest <input type="checkbox"/> Headrest <input type="checkbox"/> Rear view mirror <input type="checkbox"/> Left door <input type="checkbox"/> Right door <input type="checkbox"/> Left window <input type="checkbox"/> Right window <input type="checkbox"/> Console <input type="checkbox"/> Gear shift <input type="checkbox"/> Front seat <input type="checkbox"/> Back seat |
| Left Leg | <input type="checkbox"/> Steering wheel <input type="checkbox"/> Dashboard <input type="checkbox"/> Windshield <input type="checkbox"/> Armrest <input type="checkbox"/> Headrest <input type="checkbox"/> Rear view mirror <input type="checkbox"/> Left door <input type="checkbox"/> Right door <input type="checkbox"/> Left window <input type="checkbox"/> Right window <input type="checkbox"/> Console <input type="checkbox"/> Gear shift <input type="checkbox"/> Front seat <input type="checkbox"/> Back seat |
| Right Leg | <input type="checkbox"/> Steering wheel <input type="checkbox"/> Dashboard <input type="checkbox"/> Windshield <input type="checkbox"/> Armrest <input type="checkbox"/> Headrest <input type="checkbox"/> Rear view mirror <input type="checkbox"/> Left door <input type="checkbox"/> Right door <input type="checkbox"/> Left window <input type="checkbox"/> Right window <input type="checkbox"/> Console <input type="checkbox"/> Gear shift <input type="checkbox"/> Front seat <input type="checkbox"/> Back seat |

Patient's Initials

Date

Automobile Accident Questionnaire, continued

| The Following Questions Concern The Time Period Immediately Following The Accident | |
|--|--|
| Did you lose consciousness? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Immediately following the accident, did you feel...? | <input type="checkbox"/> Dizzy <input type="checkbox"/> Dazed <input type="checkbox"/> Disoriented <input type="checkbox"/> Weak <input type="checkbox"/> Nervous <input type="checkbox"/> Nauseated |
| Were you able to walk unaided? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Where did you go...? | <input type="checkbox"/> Drove home <input type="checkbox"/> Was driven home <input type="checkbox"/> Drove to hospital <input type="checkbox"/> Was driven to hospital <input type="checkbox"/> Drove to work <input type="checkbox"/> Was driven to work <input type="checkbox"/> Drove to school <input type="checkbox"/> Was driven to school <input type="checkbox"/> Taken to hospital via ambulance |
| In what areas did you IMMEDIATELY feel pain? | <input type="checkbox"/> Head <input type="checkbox"/> Neck <input type="checkbox"/> Upper back <input type="checkbox"/> Mid back <input type="checkbox"/> Low back <input type="checkbox"/> Ribs <input type="checkbox"/> Chest <input type="checkbox"/> Abdomen <input type="checkbox"/> Pelvis <input type="checkbox"/> Left shoulder <input type="checkbox"/> Right shoulder <input type="checkbox"/> Left arm <input type="checkbox"/> Right arm <input type="checkbox"/> Left elbow <input type="checkbox"/> Right elbow <input type="checkbox"/> Left wrist <input type="checkbox"/> Right wrist <input type="checkbox"/> Left hand <input type="checkbox"/> Right hand <input type="checkbox"/> Left fingers <input type="checkbox"/> Right fingers <input type="checkbox"/> Left buttock <input type="checkbox"/> Right buttock <input type="checkbox"/> Left Hip <input type="checkbox"/> Right Hip <input type="checkbox"/> Left thigh <input type="checkbox"/> Right thigh <input type="checkbox"/> Left knee <input type="checkbox"/> Right knee <input type="checkbox"/> Left calf <input type="checkbox"/> Right calf <input type="checkbox"/> Left ankle <input type="checkbox"/> Right ankle <input type="checkbox"/> Left foot <input type="checkbox"/> Right foot <input type="checkbox"/> Left toes <input type="checkbox"/> Right toes |
| Did your major complaints exist before the accident? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Next day discomfort...? | <input type="checkbox"/> Increased <input type="checkbox"/> Decreased <input type="checkbox"/> Same |
| Where did you experience pain on the day FOLLOWING the accident? | <input type="checkbox"/> Head <input type="checkbox"/> Neck <input type="checkbox"/> Upper back <input type="checkbox"/> Mid back <input type="checkbox"/> Low back <input type="checkbox"/> Ribs <input type="checkbox"/> Chest <input type="checkbox"/> Abdomen <input type="checkbox"/> Pelvis <input type="checkbox"/> Left shoulder <input type="checkbox"/> Right shoulder <input type="checkbox"/> Left arm <input type="checkbox"/> Right arm <input type="checkbox"/> Left elbow <input type="checkbox"/> Right elbow <input type="checkbox"/> Left wrist <input type="checkbox"/> Right wrist <input type="checkbox"/> Left hand <input type="checkbox"/> Right hand <input type="checkbox"/> Left fingers <input type="checkbox"/> Right fingers <input type="checkbox"/> Left buttock <input type="checkbox"/> Right buttock <input type="checkbox"/> Left Hip <input type="checkbox"/> Right Hip <input type="checkbox"/> Left thigh <input type="checkbox"/> Right thigh <input type="checkbox"/> Left knee <input type="checkbox"/> Right knee <input type="checkbox"/> Left calf <input type="checkbox"/> Right calf <input type="checkbox"/> Left ankle <input type="checkbox"/> Right ankle <input type="checkbox"/> Left foot <input type="checkbox"/> Right foot <input type="checkbox"/> Left toes <input type="checkbox"/> Right toes |
| In what areas did you experience lacerations (cuts)? | <input type="checkbox"/> Head <input type="checkbox"/> Neck <input type="checkbox"/> Upper back <input type="checkbox"/> Mid back <input type="checkbox"/> Low back <input type="checkbox"/> Ribs <input type="checkbox"/> Chest <input type="checkbox"/> Abdomen <input type="checkbox"/> Pelvis <input type="checkbox"/> Left shoulder <input type="checkbox"/> Right shoulder <input type="checkbox"/> Left arm <input type="checkbox"/> Right arm <input type="checkbox"/> Left elbow <input type="checkbox"/> Right elbow <input type="checkbox"/> Left wrist <input type="checkbox"/> Right wrist <input type="checkbox"/> Left hand <input type="checkbox"/> Right hand <input type="checkbox"/> Left fingers <input type="checkbox"/> Right fingers <input type="checkbox"/> Left buttock <input type="checkbox"/> Right buttock <input type="checkbox"/> Left Hip <input type="checkbox"/> Right Hip <input type="checkbox"/> Left thigh <input type="checkbox"/> Right thigh <input type="checkbox"/> Left knee <input type="checkbox"/> Right knee <input type="checkbox"/> Left calf <input type="checkbox"/> Right calf <input type="checkbox"/> Left ankle <input type="checkbox"/> Right ankle <input type="checkbox"/> Left foot <input type="checkbox"/> Right foot <input type="checkbox"/> Left toes <input type="checkbox"/> Right toes |
| At the hospital, what areas were x-rayed? (if applicable) | <input type="checkbox"/> Head <input type="checkbox"/> Neck <input type="checkbox"/> Upper back <input type="checkbox"/> Mid back <input type="checkbox"/> Low back <input type="checkbox"/> Ribs <input type="checkbox"/> Chest <input type="checkbox"/> Abdomen <input type="checkbox"/> Pelvis <input type="checkbox"/> Left shoulder <input type="checkbox"/> Right shoulder <input type="checkbox"/> Left arm <input type="checkbox"/> Right arm <input type="checkbox"/> Left elbow <input type="checkbox"/> Right elbow <input type="checkbox"/> Left wrist <input type="checkbox"/> Right wrist <input type="checkbox"/> Left hand <input type="checkbox"/> Right hand <input type="checkbox"/> Left fingers <input type="checkbox"/> Right fingers <input type="checkbox"/> Left buttock <input type="checkbox"/> Right buttock <input type="checkbox"/> Left Hip <input type="checkbox"/> Right Hip <input type="checkbox"/> Left thigh <input type="checkbox"/> Right thigh <input type="checkbox"/> Left knee <input type="checkbox"/> Right knee <input type="checkbox"/> Left calf <input type="checkbox"/> Right calf <input type="checkbox"/> Left ankle <input type="checkbox"/> Right ankle <input type="checkbox"/> Left foot <input type="checkbox"/> Right foot <input type="checkbox"/> Left toes <input type="checkbox"/> Right toes |
| At the hospital, what other treatments were provided? | <input type="checkbox"/> None <input type="checkbox"/> Other treatment? _____ _____ _____ |

Patient's Initials

Date

Automobile Accident Questionnaire, continued

| Have you seen any other health care provider(s) for evaluation or management of conditions related to this accident? | |
|--|--|
| Who? | <input type="checkbox"/> None <input type="checkbox"/> Provider's name: _____ |
| When? | _____ |
| What treatments, testing or referrals were done? | <input type="checkbox"/> None <input type="checkbox"/> Treatments/testing/referrals: _____ _____ |
| Did you receive any prescriptions for drugs related to this accident? | <input type="checkbox"/> No <input type="checkbox"/> Yes. If yes, please list: _____ |
| Additional information pertinent to the auto accident not already covered: | _____ _____ _____ _____ |
| Doctor's Notes: | _____ _____ _____ _____ |

Patient's Initials

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