Walsh Family Chiropractic Center | 1139 Professional Drive | Williamsburg, VA 23185| 757.220.4917 | 757.220.5884, fax

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?	☐ Driver ☐ Passenger --- Position: ☐ Left ☐ Middle ☐ Right ☐ Front Passenger ☐ Rear Passenger ☐ Third Row (rear)
Vehicle size?	☐ Subcompact ☐ Full-size ☐ Compact ☐ Mini ☐ Mid-size ☐ Light ☐ Heavy ☐ Other: _______________
Vehicle type?	☐ Car ☐ Van ☐ Pickup ☐ Truck ☐ Station Wagon ☐ Bus ☐ SUV ☐ Other: ______________
What was the speed of your vehicle?	☐ Stopped ☐ Parked ☐ Slowing ☐ Moving Slowly ☐ Moving Moderately ☐ Moving Fast ☐ Moving at approx ________ MPH
Why was your vehicle slowed/ stopped?(if app)	☐ Traffic Signal ☐ Parking ☐ Pedestrian ☐ Traffic ☐ Stop Sign ☐ Busy Intersection
Collision type?	☐ Driver Side Impact ☐ Passenger Side Impact ☐ Front Impact ☐ Head on Collision ☐ Rear Impact ☐ 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?	☐ Subcompact ☐ Full-size ☐ Compact ☐ Mini ☐ Mid-size ☐ Light ☐ Heavy ☐ Other: _______________
Vehicle type?	☐ Car ☐ Van ☐ Pickup ☐ Truck ☐ Station Wagon ☐ Bus ☐ SUV ☐ Other: ______________
What was the speed of other vehicle?	☐ Stopped ☐ Parked ☐ Slowing ☐ Moving Slowly ☐ Moving Moderately ☐ Moving Fast ☐ 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 affected 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?	☐ Lap belt & shoulder harness ☐ Shoulder harness only ☐ Lap belt only ☐ No restraints
Was the air bag deployed?	☐ Car not equipped with air bag ☐ Air bag deployed ☐ Air bag not deployed

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Patient's Signature **Date**

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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
Position of YOUR body at time of impact?	☐ Straight ☐ 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 right ☐ To the left, then the right ☐ To the right, then the left
Was your body thrown…?	☐ Backward and then forward ☐ Forward then backward ☐ To the left ☐ To the right ☐ To the left, then 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, 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 ☐ Back seat
Left Arm	☐ Steering wheel ☐ Dashboard ☐ Windshield ☐ Armrest ☐ Headrest ☐ Rear view mirror ☐ Left door ☐ Right door ☐ Left window ☐ Right window ☐ Console ☐ Gear shift ☐ Front seat ☐ Back seat
Right Arm	☐ Steering wheel ☐ Dashboard ☐ Windshield ☐ Armrest ☐ Headrest ☐ Rear view mirror ☐ Left door ☐ Right door ☐ Left window ☐ Right window ☐ Console ☐ Gear shift ☐ Front seat ☐ Back seat
Torso	☐ Steering wheel ☐ Dashboard ☐ Windshield ☐ Armrest ☐ Headrest ☐ Rear view mirror ☐ Left door ☐ Right door ☐ Left window ☐ Right window ☐ Console ☐ Gear shift ☐ Front seat ☐ Back seat
Left Leg	☐ Steering wheel ☐ Dashboard ☐ Windshield ☐ Armrest ☐ Headrest ☐ Rear view mirror ☐ Left door ☐ Right door ☐ Left window ☐ Right window ☐ Console ☐ Gear shift ☐ Front seat ☐ Back seat
Right Leg	☐ Steering wheel ☐ Dashboard ☐ Windshield ☐ Armrest ☐ Headrest ☐ Rear view mirror ☐ Left door ☐ Right door ☐ Left window ☐ Right window ☐ Console ☐ Gear shift ☐ Front seat ☐ Back seat

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Patient's Initials **Date**

Automobile Accident Questionnaire

The Following Questions Concern The Time Period Immediately Following The Accident	
Did you lose consciousness?	☐ Yes ☐ No
Immediately following the accident, did you feel…?	☐ 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 ☐ Drove to work ☐ Was driven to work ☐ Drove to school ☐ Was driven to school ☐ Taken to hospital via ambulance
In what areas did you IMMEDIATELY feel pain?	☐ Head ☐ Neck ☐ Upper back ☐ Mid back ☐ Low back ☐ Ribs ☐ Chest ☐ Abdomen ☐ Pelvis ☐ Left shoulder ☐ Right shoulder ☐ Left arm ☐ Right arm ☐ Left elbow ☐ Right elbow ☐ Left wrist ☐ Right wrist ☐ Left hand ☐ Right hand ☐ Left fingers ☐ Right fingers ☐ Left buttock ☐ Right buttock ☐ Left Hip ☐ Right Hip ☐ Left thigh ☐ Right thigh ☐ Left knee ☐ Right knee ☐ Left calf ☐ Right calf ☐ Left ankle ☐ Right ankle ☐ Left foot ☐ Right foot ☐ Left toes ☐ Right toes
Did your major complaints exist before the accident?	☐ Yes ☐ No
Next day discomfort…?	☐ Increased ☐ Decreased ☐ Same
Where did you experience pain on the day FOLLOWING the accident?	☐ Head ☐ Neck ☐ Upper back ☐ Mid back ☐ Low back ☐ Ribs ☐ Chest ☐ Abdomen ☐ Pelvis ☐ Left shoulder ☐ Right shoulder ☐ Left arm ☐ Right arm ☐ Left elbow ☐ Right elbow ☐ Left wrist ☐ Right wrist ☐ Left hand ☐ Right hand ☐ Left fingers ☐ Right fingers ☐ Left buttock ☐ Right buttock ☐ Left Hip ☐ Right Hip ☐ Left thigh ☐ Right thigh ☐ Left knee ☐ Right knee ☐ Left calf ☐ Right calf ☐ Left ankle ☐ Right ankle ☐ Left foot ☐ Right foot ☐ Left toes ☐ Right toes
In what areas did you experience lacerations (cuts)?	☐ Head ☐ Neck ☐ Upper back ☐ Mid back ☐ Low back ☐ Ribs ☐ Chest ☐ Abdomen ☐ Pelvis ☐ Left shoulder ☐ Right shoulder ☐ Left arm ☐ Right arm ☐ Left elbow ☐ Right elbow ☐ Left wrist ☐ Right wrist ☐ Left hand ☐ Right hand ☐ Left fingers ☐ Right fingers ☐ Left buttock ☐ Right buttock ☐ Left Hip ☐ Right Hip ☐ Left thigh ☐ Right thigh ☐ Left knee ☐ Right knee ☐ Left calf ☐ Right calf ☐ Left ankle ☐ Right ankle ☐ Left foot ☐ Right foot ☐ Left toes ☐ Right toes
At the hospital, what areas were x-rayed? (if applicable)	☐ Head ☐ Neck ☐ Upper back ☐ Mid back ☐ Low back ☐ Ribs ☐ Chest ☐ Abdomen ☐ Pelvis ☐ Left shoulder ☐ Right shoulder ☐ Left arm ☐ Right arm ☐ Left elbow ☐ Right elbow ☐ Left wrist ☐ Right wrist ☐ Left hand ☐ Right hand ☐ Left fingers ☐ Right fingers ☐ Left buttock ☐ Right buttock ☐ Left Hip ☐ Right Hip ☐ Left thigh ☐ Right thigh ☐ Left knee ☐ Right knee ☐ Left calf ☐ Right calf ☐ Left ankle ☐ Right ankle ☐ Left foot ☐ Right foot ☐ Left toes ☐ Right toes
At the hospital, what other treatments were provided?	☐ None ☐ Other treatment? ______________________ ______________________ ______________________

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At the hospital, what other treatments were provided?	☐ None ☐ Other treatment? ______________________ ______________________ ______________________

______________________ **Patient's Initials**

______________________ **Date**

Automobile Accident Questionnaire

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

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Patient's Initials **Date**