

# AUTOMOBILE ACCIDENT QUESTIONNAIRE

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Patient's Name: \_\_\_\_\_  
Today's Date: \_\_\_\_\_  
Date of Accident: \_\_\_\_\_

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

### Your position in the vehicle:

- Driver  Passenger ----- Location-----  
 Left  Middle  Right  Other \_\_\_\_\_  
 Front Passenger  Rear Passenger  Third Seat (rear)

### Vehicle size:

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

### Vehicle type:

- Car  Truck  Other \_\_\_\_\_  
 Van  Bus  
 Station Wagon  Sport Utility  
 Pickup  Crossover

### Speed of your vehicle:

- Stopped  Moving Moderately  
 Parked  Moving Fast  
 Slowing  Moving at approx \_\_\_\_ MPH  
 Moving Slowly  Other \_\_\_\_\_

### Why Vehicle was slowed or stopped:

- Traffic Signal  Parking  
 Pedestrian  Traffic  
 Stop Sign  Busy Intersection  
 Other \_\_\_\_\_

### Collision Type:

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

## THE FOLLOWING QUESTIONS CONCERN THE OTHER VEHICLE INVOLVED IN THE ACCIDENT: N/A

### Vehicle size:

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

### Vehicle type:

- Car  Pickup  
 Van  Truck  
 Station Wagon  Bus  
 Other \_\_\_\_\_

## CONDITIONS AT THE TIME OF THE ACCIDENT: N/A

### Time of day:

- Full daylight  
 Dawn  
 Dusk  
 Night  
 Other \_\_\_\_\_

### Road Conditions:

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

### Visibility:

- Excellent  
 Good  
 Fair  
 Poor  
 Other \_\_\_\_\_

### Visibility compromised by:

- Brightness  
 Darkness  
 Rain  
 Snow  
 Fog  
 Traffic

## THE FOLLOWING QUESTIONS CONCERN THE MOMENT OF IMPACT OF THE ACCIDENT: N/A

### 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? N/A

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

### What position was YOUR headrest in? N/A

- High position  
 Middle position  
 Low position

**Position of YOUR head at time of impact?**  N/A

- Facing straight ahead
- Tilted forward
- Rotated to the left
- Rotated to the right

**Was your head thrown...?**  N/A

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

**Position of Your body at time of impact?**  N/A

- Straight
- Tilted forward
- Rotated to the left
- Rotated to the right

**Was your body thrown...?**  N/A

- Backward and then forward
- Forward then backward
  - To the left  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:**  N/A

- Minimal damage  Was totaled
- Moderate damage  Not known
- Severe damage  Other

**Citations:**  N/A

- None issued  Driver of other vehicle
- Yourself  Not sure
- Driver of vehicle patient was a passenger of

**AS A RESULT OF THE FORCE OF THE COLLISION, WHICH OBJECTS IN THE VEHICLE DID YOUR BODY STRIKE?**

**Head**  N/A

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

**Left Arm**  N/A

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

**Right Arm**  N/A

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

**Torso**  N/A

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

**Left Leg**  N/A

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

**Right Leg**  N/A

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

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  Weak  None
- Dazed  Nervous  Other \_\_\_\_\_
- Disoriented  Nauseated

**Were you able to walk unaided?**

- Yes
- No

**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  Other \_\_\_\_\_

**Next day discomfort...?**

increased decreased same

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

Yes  No

**In what areas did you IMMEDIATELY feel pain?  N/A**

<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					

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

<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					

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

<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?  N/A**

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

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