

AUTOMOBILE ACCIDENT QUESTIONNAIRE

Patient's Name: _____

Today's Date: _____

Date of Accident: _____

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

Vehicle type:

- ☐ Car ☐ Pickup
☐ Van ☐ Truck
☐ Station Wagon ☐ Bus
☐ Other _____

Vehicle size:

- ☐ Subcompact ☐ Full-size
☐ Compact ☐ Mini
☐ Mid-size ☐ Light
☐ Heavy ☐ Other _____

Your position in the vehicle:

- ☐ Driver
☐ Passenger Location ----- ☐ Left ☐ Middle ☐ Right
☐ Other _____ ☐ Front Passenger ☐ Rear Passenger ☐ Third Seat (rear)

Speed of your vehicle:

- ☐ Stopped ☐ Moving Moderately
☐ Parked ☐ Moving Fast
☐ Slowing ☐ Moving at apprx ____ MPH
☐ Moving Slowly

Why Vehicle was slowed or stopped:

- ☐ Traffic Signal ☐ Parking
☐ Pedestrian ☐ Traffic
☐ Stop Sign ☐ 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
☐ Station Wagon ☐ Bus
☐ Other _____

Vehicle size:

- ☐ Subcompact ☐ Full-size
☐ Compact ☐ Mini
☐ Mid-size ☐ Light
☐ Heavy ☐ Other _____

CONDITIONS AT THE TIME OF THE ACCIDENT:

Time of day:

- ☐ Full daylight
☐ Dusk
☐ Night

Road Conditions:

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

Visibility:

- ☐ Excellent
☐ Good
☐ Fair
☐ Poor

Visibility compromised 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: (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

Position of Your body at time of impact?

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

Damage to vehicle YOU were in:

- ☐ Incurred minimal damage
- ☐ Incurred moderate damage
- ☐ Incurred severe damage
- ☐ Was totalled
- ☐ Not known

Was your head thrown...?

- ☐ 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

Was your body thrown...?

- ☐ 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

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**

- | | |
|---|---------------------------------------|
| <input type="checkbox"/> Steering wheel | <input type="checkbox"/> Right door |
| <input type="checkbox"/> Dashboard | <input type="checkbox"/> Left window |
| <input type="checkbox"/> Windshield | <input type="checkbox"/> Right window |
| <input type="checkbox"/> Armrest | <input type="checkbox"/> Console |
| <input type="checkbox"/> Headrest | <input type="checkbox"/> Gear shift |
| <input type="checkbox"/> Rear view mirror | <input type="checkbox"/> Front seat |
| <input type="checkbox"/> Left door | <input type="checkbox"/> Backseat |

Right Arm

- | | |
|---|---------------------------------------|
| <input type="checkbox"/> Steering wheel | <input type="checkbox"/> Right door |
| <input type="checkbox"/> Dashboard | <input type="checkbox"/> Left window |
| <input type="checkbox"/> Windshield | <input type="checkbox"/> Right window |
| <input type="checkbox"/> Armrest | <input type="checkbox"/> Console |
| <input type="checkbox"/> Headrest | <input type="checkbox"/> Gear shift |
| <input type="checkbox"/> Rear view mirror | <input type="checkbox"/> Front seat |
| <input type="checkbox"/> Left door | <input type="checkbox"/> Backseat |

Left Leg

- | | |
|---|---------------------------------------|
| <input type="checkbox"/> Steering wheel | <input type="checkbox"/> Right door |
| <input type="checkbox"/> Dashboard | <input type="checkbox"/> Left window |
| <input type="checkbox"/> Windshield | <input type="checkbox"/> Right window |
| <input type="checkbox"/> Armrest | <input type="checkbox"/> Console |
| <input type="checkbox"/> Headrest | <input type="checkbox"/> Gear shift |
| <input type="checkbox"/> Rear view mirror | <input type="checkbox"/> Front seat |
| <input type="checkbox"/> Left door | <input type="checkbox"/> Backseat |

Left Arm

- | | |
|---|---------------------------------------|
| <input type="checkbox"/> Steering wheel | <input type="checkbox"/> Right door |
| <input type="checkbox"/> Dashboard | <input type="checkbox"/> Left window |
| <input type="checkbox"/> Windshield | <input type="checkbox"/> Right window |
| <input type="checkbox"/> Armrest | <input type="checkbox"/> Console |
| <input type="checkbox"/> Headrest | <input type="checkbox"/> Gear shift |
| <input type="checkbox"/> Rear view mirror | <input type="checkbox"/> Front seat |
| <input type="checkbox"/> Left door | <input type="checkbox"/> Backseat |

Torso

- | | |
|---|---------------------------------------|
| <input type="checkbox"/> Steering wheel | <input type="checkbox"/> Right door |
| <input type="checkbox"/> Dashboard | <input type="checkbox"/> Left window |
| <input type="checkbox"/> Windshield | <input type="checkbox"/> Right window |
| <input type="checkbox"/> Armrest | <input type="checkbox"/> Console |
| <input type="checkbox"/> Headrest | <input type="checkbox"/> Gear shift |
| <input type="checkbox"/> Rear view mirror | <input type="checkbox"/> Front seat |
| <input type="checkbox"/> Left door | <input type="checkbox"/> Backseat |

Right Leg

- | | |
|---|---------------------------------------|
| <input type="checkbox"/> Steering wheel | <input type="checkbox"/> Right door |
| <input type="checkbox"/> Dashboard | <input type="checkbox"/> Left window |
| <input type="checkbox"/> Windshield | <input type="checkbox"/> Right window |
| <input type="checkbox"/> Armrest | <input type="checkbox"/> Console |
| <input type="checkbox"/> Headrest | <input type="checkbox"/> Gear shift |
| <input type="checkbox"/> Rear view mirror | <input type="checkbox"/> Front seat |
| <input type="checkbox"/> Left door | <input type="checkbox"/> 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...?

- | | |
|--------------------------------------|------------------------------------|
| <input type="checkbox"/> Dizzy | <input type="checkbox"/> Weak |
| <input type="checkbox"/> Dazed | <input type="checkbox"/> Nervous |
| <input type="checkbox"/> Disoriented | <input type="checkbox"/> Nauseated |

Were you able to walk unaided?

- ☐ Yes
☐ No

Where did you go...?

- | | |
|--|---|
| <input type="checkbox"/> Drove home | <input type="checkbox"/> Drove to work |
| <input type="checkbox"/> Was driven home | <input type="checkbox"/> Was driven to work |
| <input type="checkbox"/> Drove to hospital | <input type="checkbox"/> Drove to school |
| <input type="checkbox"/> Was driven to hospital | <input type="checkbox"/> Was driven to school |
| <input type="checkbox"/> 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 IMMEDIATELY feel pain?

- | | | | | | | |
|---|----------|-------------------------------|--------------------------------|-------|-------------------------------|--------------------------------|
| <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)?

- | | | | | | | |
|---|----------|-------------------------------|--------------------------------|-------|-------------------------------|--------------------------------|
| <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?

- | | | | | | | |
|---|----------|-------------------------------|--------------------------------|-------|-------------------------------|--------------------------------|
| <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?

- | | | | | | | |
|---|----------|-------------------------------|--------------------------------|-------|-------------------------------|--------------------------------|
| <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 | | | | | | |

Patient's Signature: _____