AUTOMOBILE ACCIDENT QUESTIONNAIRE

Patient's Name:____________________ Today's Date:_________________

What was the cause of the injury?

□automobile vs. automobile
□automobile vs. object(non-vehicle)
□motorcycle/bicycle vs. vehicle
□motorcycle/bicycle vs. object(non-vehicle)
□pedestrian vs. vehicle
□pedestrian vs. non-vehicle (e.g; slip, trip)

THE FOLLOWING QUESTIONS PERTAIN TO *YOU/THE PATIENT* AND THE VEHICLE YOU WERE IN:

Your/the patient's position in the vehicle:

□driver
□passenger-----Location-----□Left □Middle □Right
□other □Front □Rear □Third Seat(rear)

Your/the patient's type of vehicle:

Vehicle type:

□car □pick-up
□van □truck
□station Wagon □bus
make and model______________

Your/the patient's size of vehicle:

Vehicle size:

□fullsize □mini
□compact □sub-compact
□mid-size □heavy
□Other

THE FOLLOW QUESTIONS PERTAIN TO THE *OTHER VEHICLE* INVOLVED IN THE ACCIDENT:

Vehicle type:

□car □pick-up
□van □truck
□station Wagon □bus
make and model______________

Vehicle size:

□fullsize □mini
□compact □sub-compact
□mid-size □heavy
□Other

THE FOLLOWING QUESTIONS CONCERN THE MOMENT OF IMPACT OF THE ACCIDENT:

Date of accident: _________________

Where were you/ the patient seated in the vehicle?

□driver
□front seat passenger
□rear right seat passenger
□rear left seat passenger
□rear middle seat passenger
□rear right seat passenger in a car seat
□rear left seat passenger in a car seat
□rear right seat passenger in a booster seat
□rear left seat passenger in a booster seat
□rear middle seat passenger in a car seat

Restrained or unrestrained?

□restrained □unrestrained □OTHER □uncertain

Did the airbag deploy?

☐Did ☐Did not ☐OTHER

Did your/the patient's seat break at the time of collision?

☐Did ☐Did not ☐OTHER

Position of the headrest?

☐low position relative to the head
☐mid position relative to the head
☐high position relative to the head
☐was not present
☐was integrated into the child car seat
☐was the seatback with child in booster seat

Did your/the patient's head hit the headrest?

☐Did ☐Did not

Which way was your/the patient's head pointing at the time of impact?

☐Straight ☐Down ☐to the left ☐to the right ☐unknown

Did you/the patient contact the interior of the vehicle?

☐Did ☐Did not ☐OTHER

Please list any parts of the body that came in contact with the interior:(Ex. Head, leg, arm, knee etc.)

____

____

Interior of the vehicle body contacted?

☐no interior parts contacted at time of accident
☐any object in the car
☐the airbag
☐the armrest
☐the dashboard
☐the door
☐flying objects inside vehicle
☐the headrest
☐the seat
☐the steering wheel
☐the window
☐other

Did you/the patient receive an injury to the head?

☐Did ☐Did not ☐OTHER

Did you/the patient lose consciousness?

☐Did ☐Did not ☐OTHER

Patient's vehicle impact?

☐on the front right side
☐on the front left side
☐on the front center
☐on the rear right side
☐on the rear end
☐on the right side(passenger's side)
☐on the left side(driver's side)
☐Other

Patient's vehicle movement?

☐backing up ☐turning left
☐moving forward ☐turning right
☐stopped ☐not specified/unknown

What was the estimated speed of the vehicle you/the patient was driving in?

☐not moving(0 MPH) ☐moving at a moderate speed(between 25 and 40 MPH)
☐moving very slowly(less than15 MPH) ☐moving at an increased speed(between 40 and 65 MPH)
☐moving slowly(between 15 and 25 MPH) ☐moving at an excessive speed(more than 65 MPH)

Your/the patient's vehicle estimated damage:

☐Unknown ☐Slight visible damage ☐other
☐Heavy visible damage ☐No visible damage
☐Moderate visible damage ☐Totaled

THE FOLLOW QUESTIONS PERTAIN TO THE *OTHER VEHICLE* INVOLVED IN THE ACCIDENT:

OTHER vehicles movement:

☐backing up ☐turning left
☐moving forward ☐turning right
☐stopped ☐not specified/unknown

What was the estimated speed of the OTHER vehicle?

☐not moving(0 MPH) ☐moving at a moderate speed(between 25 and 40 MPH)
☐moving very slowly(less than15 MPH) ☐moving at an increased speed(between 40 and 65 MPH)
☐moving slowly(between 15 and 25 MPH) ☐moving at an excessive speed(more than 65 MPH)

How much damage is estimated to OTHER vehicle?

☐Unknown ☐Slight visible damage ☐other
☐Heavy visible damage ☐No visible damage
☐Moderate visible damage ☐Totaled

Was your/the patient's vehicle towed from the scene?

☐Was ☐Was not ☐May or may not have been

Did the police arrive at the scene?

☐did ☐did not ☐unknown

Was there an accident report?

☐Was ☐Was not ☐May or may not have been

Was EMS at the scene?

☐Was ☐Was not ☐May or may not have been

If yes to above, How did you/the patient get to the hospital?

☐Ambulance ☐Drove myself ☐Was driven by someone else

Has the patient received any treatment since the accident?

☐not treated since the accident ☐referred to physical therapy
☐examined, then released without treatment☐referred to a chiropractor
☐examined & prescribed medication ☐referred to a neurologist
☐referred for further evaluation and treatment ☐referred to an orthopedist
☐referred to a primary care provider ☐treated by a surgeon
☐released ☐released that day
☐treated by self at home with heat ☐treated by self at home with cold
☐treated by self with over the counter medication ☐treated by self at home with rest

Describe the discomfort felt at the time of the accident:

☐sharp ☐general discomfort ☐heavy ☐stabbing
☐dull ☐numbness ☐intolerable ☐stiffness
☐aching ☐annoying ☐pulling ☐tightness
☐burning ☐deep ☐pulling ☐tingling
☐throbbing ☐diffuse ☐shock

Where were the symptoms felt at the time of the accident?

Please list where the symptoms were felt:(eg. neck, mid back, leg, wrist etc)

____
____

Additional symptoms at the time of the accident?

☐Anxiety ☐Dizziness ☐Shock ☐Other___________
☐Discomfort ☐Exhaustion ☐Stress
☐Difficulty breathing ☐Facial pain ☐Tightness
☐Chest pain ☐Headache ☐Tiredness
☐Depression ☐Irritability ☐Upset
☐Disbelief ☐Numbness and tingling ☐Stunned

Status of symptoms since the accident?

☐elicited more pain ☐improved
☐elicited more stiffness ☐improved daily functioning at work/home
☐exacerbated ☐elicited less pain
☐deteriorated daily functioning at work/home ☐elicited less stiffness
☐worsened ☐lessened
☐worsened quality of life ☐somewhat resolved
☐shown no change in daily functioning at work/home ☐stayed the same
☐disappeared ☐other______________________

Patient's Signature_________________________ Date:____________________