AUTOMOBILE ACCIDENT QUESTIONNAIRE

Patient Name: _____ **Date of Accident: _____**

Please answer the following question regarding your automobile accident as best you can. If you don't know the answer or it does not apply, please leave it blank.

1. **Your vehicle type:**
   ____Car ____SUV ____Minivan ____Pickup Truck ____Cab ____Bus ____Other (describe): _____

2. **Other vehicle type:**
   ____Car ____SUV ____Minivan ____Pickup Truck ____Cab ____Bus ____Other (describe): _____

3. **Your position in the vehicle:**
   ___Driver ___Front Passenger ___Left Rear Passenger ___Right Rear Passenger ___Other (describe): _____

4. **What was your vehicle doing at the time of the accident? (check all that apply)**
   ____Stopped at intersection ____Stopped in traffic ____Making a right turn ____ Making a left turn ____Stopped/Parked
   ____Slowing down ____Accelerating ____Backing Up ____On city/town street ____On highway
   ____Other (describe): _____

5. **Who hit whom/what:**
   ____Other vehicle hit you ____You hit other vehicle ____You hit (object): _____
   After impact, did your vehicle hit anything else? ____Yes ____No If yes, describe: _____

6. **Point of impact:**
   ____Head on ____Rear ended ____Driver's side front ____Driver's side rear ____Non driver's side front ____Non driver's side rear

7. **Speed/Road Conditions:**
   Your vehicle's speed: ____mph Other vehicle's speed: ____mph Visibility: ____Good ____Fair ____Poor
   Road Conditions (check all that apply): ____Dry ____Wet ____Icy ____Snow covered ____Sandy

8. **Damage:**
   Damage to your vehicle (circle): None /Mild/Moderate/Totaled Damage to other vehicle (circle): None/Mild/Moderate/Totaled
   Police present? ____Yes ____No If yes, was a police report filled out? ____Yes ____No

9. **Restraints/Air bags:**
   Seat belted? ____Yes ____No Did air bag(s) deploy? ____Yes ____No If Yes, which ones? _____

10. **Body Position/Awareness:**
    What was your head position at time of impact? ____Facing forward ____Turned left ____Turned right ____Unsure
    Did you see accident coming? ____Yes ____No Did you brace for impact? ____Yes ____No
    Did any part of your body strike any part of the interior of your vehicle on impact? ____Yes ____ No If yes, describe: _____
    Did you lose consciousness? ____Yes ____No If yes, for how long? _____

11. **Events following the accident:**
    Did you go to the ER? ____Yes ____No If yes, how were you taken? ____By ambulance ____Drove yourself ____Driven by someone
    When did you go? ___Immediately after accident ___Later date (when?) _____ Name of Hospital:_____
    Treatment done: ____Exam ____X-rays ____Other testing? (describe) _____
    Medications prescribed: _____

12. **Symptoms after accident(check all that apply):**
    ____Neck Pain ____Middle back pain ____Lower back pain ____Headaches ____Dizziness ____Nausea
    ____Shoulder Pain ____Arm/Wrist/Hand pain ____Hip/Leg pain ____Knee pain ____Foot/Ankle pain
    ____Chest Pain ____Heart Palpitations ____Pins/Needles ____Numbness ____Weakness
    ____Other: (describe) _____

13. **OTHER INFORMATION- Please provide any additional information on the back of this paper that you feel is important regarding the details of the accident. Thank you.**

Patient Initials: _____