AUTOMOBILE ACCIDENT QUESTIONAIRE

Dear Patient:
This questionnaire will allow you to describe your automobile accident in detail. Please complete it carefully as the information provided will assist the doctor in evaluating and documenting your condition. THANK YOU.

PATIENT NAME:_____ DATE:_____

A. ACCIDENT INFORMATION

1. Date of Accident:_____Time: _____
2. Location of Accident (Street, City, State):_____
3. Did the police come to the accident scene? _____Yes _____No
4. Were you taken to a hospital? _____Yes _____No
   i. What is the name and location of the hospital? _____
   ii. How did you get to the hospital? _____
   iii. Did you get X-rays? What parts of your body were x-rayed? _____

B. VECHILE YOU WERE IN

1. Vehicle Type:

____Car ____Van ____Pickup ____Truck
____Station Wagon ____Bus ____Other:

2. Vehicle Size:

____Subcompact ____Compact ____Full-size ____Mid-Size
____Mini ____Light ____Other:

3. What was your location in the Vehicle?

____Driver ____Front Passenger ____Rear Passenger
Passenger location: ____Left ____Middle ____Right
____Other:

4. What was the vehicle you were in doing?

a. Vehicle was stopped for:
____Traffic light ____Intersection ____Stop Sign ____Traffic
____Pedestrian ____Parked ____Other:

b. Vehicle slowing down for:
____Traffic light ____Intersection ____Stop Sign ____Traffic
____Pedestrian ____Turning ____Parking ____Other:

c. Vehicle moving
____Slowly ____Moderately ____Fast ____Accelerating
____Other: SPEED: ____MPH

d. Vehicle doing other:
Explain:

5. What damage did the vehicle you were in sustain?

____Minimal ____Moderate ____Extensive ____Totaled
____Unsure ____Other:

6. What is the cost damage of the vehicle you were in? _____

7. If you have been in previous auto accidents, please list the year each was in: _____

C. IF OTHER VEHICLE INVOLVED IN ACCIDENT

1. First Vehicle to Strike Vehicle you were in:

a. Vehicle Type:
____Car ____Van ____Station Wagon ____Pickup
____Truck ____Bus ____Other:

b. Vehicle Size:
____Subcompact ____Compact ____Mid-Size ____Full-Size
____Mini ____Light ____Other:

c. How did this vehicle strike the vehicle you were in:
____Head on ____From Right ____From Left ____Rear Ended
____Sideswiped on Right ____Sideswiped on Left ____Other:

d. What damage did this vehicle sustain:
____Minimal ____Moderate ____Extensive ____Totaled
____Unsure ____Other:

2. Second Vehicle to Strike Vehicle you were in:

a. Vehicle Type:
____Car ____Van ____Station Wagon ____Pickup
____Truck ____Bus ____Other:

b. Vehicle Size:
____Subcompact ____Compact ____Mid-Size ____Full-Size
____Mini ____Light ____Other:

c. How did this vehicle strike the vehicle strike the vehicle you were in?
____Head on ____From Right ____From Left ____Rear Ended
____Sideswiped on Right ____Sideswiped on Left ____Other:

d. What damage did this vehicle sustain?
____Minimal ____Moderate ____Extensive ____Totaled
____Unsure ____Other:

3. Describe other vehicles to strike vehicle you were in:

Vehicle Type: How it struck:
Vehicle Size: Damage:

4. Were traffic citations issued as result of accident:

____No Citations Issued ____You ____Unsure
____Driver of other Vehicle ____Driver of vehicle you were in

D. CONDITIONS AT TIME OF ACCIDENT

1. What time of day did the accident occur?

____Daylight ____Dawn ____Dusk ____Night
____Other:

2. What was the condition of the road?

____Dry ____Damp ____Wet ____Snow Covered
____Icy ____Other:

3. Visibility:

a. What was the visibility at impact:
____Good ____Fair ____Poor ____Other:

b. If visibility was poor, why
____Sun Light ____Darkness ____Rain ____Snow
____Fog
____Traffic ____Other:

E. AT MOMENT OF IMPACT

1. Were you prepared for the accident:

____Accident a complete surprise ____Aware of impending collision
____And braced for impact

2. Foot on Brake Pedal:

a. Was you foot on brake pedal at impact: ____Yes ____No
b. Was it knocked off pedal by impact: ____Yes ____No

3. Use of Restraints:

a. Restraint Belts:

i. Were you wearing a restraint belt? ____Yes ____No

ii. What type of restrain belt were you wearing?

____Shoulder-lap Belt ____Shoulder Belt ____Lap Belt

b. Headrest

i. Was vehicle equipped with headrest: ____Yes ____No

ii. What position was headrest in:

____Low ____Middle ____High ____Don't Know

c. Airbags

i. Was vehicle equipped with air bags? ____Yes ____No

ii. Did the air bags deploy? ____Yes ____No

d. Did you lose consciousness (black out) upon impact? ____Yes ____No

i. For how long? _____

4. Your Body

a. What was your body position at impact:

____Straight ____Slouched Forward ____Rotated Right ____Rotated Left

____Don't Recall ____Other:

b. What direction was your body thrown:

____Forward/Backward ____Backward/Forward ____Sideways

____Across Vehicle ____Outside Vehicle ____Under Vehicle

____Don't Recall ____Other:

c. Did you receive any bleeding cuts? If so, where? _____

5. Your Head and Neck

a. How far is the top of the headrest or backseat from the top of your head? _____inches

Is this distance above or below the top of your head?

a. What position were your head/neck in at impact?

____Straight ____Tilted Forward ____Rotated Right ____Rotated Left

____Don't Recall ____Other:

b. Through what motion were your head/neck pitched?

____Forward/Backward ____Backward/Forward ____Sideways

____Don't Recall ____Other:

F. RESULT OF IMPACT

1. Which objects in the vehicle did the force of the collision cause your body to strike:

a. Head

____Steering Wheel ____Dashboard ____Windshield ____Right Side Door

____Left Side Door ____Armrest ____Right Window ____Left Window

____Headrest ____Ceiling ____Console ____Shift Lever

____Front Seat ____Rear View Mirror ____Airbag ____Other:

b. Right Upper Extremity (Arm)

____Steering Wheel ____Dashboard ____Windshield ____Right Side Door

____Left Side Door ____Armrest ____Right Window ____Left Window

____Headrest ____Ceiling ____Console ____Shift Lever

____Front Seat ____Rear View Mirror ____Airbag ____Other:

c. Left Upper Extremity (Arm)

____Steering Wheel	____Dashboard	____Windshield	____Right Side Door
____Left Side Door	____Armrest	____Right Window	____Left Window
____Headrest	____Ceiling	____Console	____Shift Lever
____Front Seat	____Rear View Mirror	____Airbag	____Other:

d. Torso:

____Steering Wheel	____Dashboard	____Windshield	____Right Side Door
____Left Side Door	____Armrest	____Right Window	____Left Window
____Headrest	____Ceiling	____Console	____Shift Lever
____Front Seat	____Rear View Mirror	____Airbag	____Other:

e. Right Lower Extremity (Leg)

____Steering Wheel	____Dashboard	____Windshield	____Right Side Door
____Left Side Door	____Armrest	____Right Window	____Left Window
____Headrest	____Ceiling	____Console	____Shift Lever
____Front Seat	____Rear View Mirror	____Airbag	____Other:

f. Left Lower Extremity (Leg)

____Steering Wheel	____Dashboard	____Windshield	____Right Side Door
____Left Side Door	____Armrest	____Right Window	____Left Window
____Headrest	____Ceiling	____Console	____Shift Lever
____Front Seat	____Rear View Mirror	____Airbag	____Other:

2. Did your body strike any other objects: _____

G. ADDITIONAL INFORMATION

1. In your own words please describe the accident. Were your moving or stopped? Etc.

_____

_____

_____

_____

_____

Patient or Guardian Signature	**Date**