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.

PATII	ENT NAME:	D A	ATE:	
A. A	CCIDENT INFORMATION			
	Date of Accident:		Time:	
2.	Location of Accident (Street, C	City, State):		
3.	Did the police come to the acci	dent scene? Yes	No	
		Yes		
	i. What is the name and lo			
	ii. How did you get to the h	nospital?		
	iii. Did you get X-rays? Wh	at parts of your body were	e x-rayed?	
B. VE	CCHILE YOU WERE IN			
1	Val. al. Tom.			
1.	Vehicle Type:	X 7	D' -1	T1-
	Car	Van	Pickup	Truck
	Station Wagon	Bus	Other:	
2.	Vehicle Size:			
	Subcompact	Compact	Full-size	Mid-Size
	Mini	Light	Other:	
		<i>U</i>		
3.	3			
		Front Passenger	Rear Passenger	
	Passenger location:	Left	Middle	Right
				Other:
4.	•	re 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:			
_	What damage did the vehicle	wan wana in anatain?		
5.		Moderate	Extensive	Totalad
	Minimal Unsure	Other:	Extensive	Totaled
	Offsure	Other:		
6.	What is the cost damage of the	vehicle you were in?		
7.	If you have been in previous au	to accidents, please list tl	he year each was in:	
C. IF	OTHER VEHICLE INVOLVE	D IN ACCIDENT		
1.	First Vehicle to Strike Vehicle	e vou were in:		
	a. Vehicle Type:	J CAR TI CA C AARD		
	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 t			
Head on	From Right	From Left	Rear Ended
Sideswiped on Right		I Ioni Leit	Other:
			Ouler.
d. What damage did this vehicle		.	m . 1 .
Minimal	Moderate	Extensive	Totaled
Unsure	Other:		
2. Second Vehicle to Strike Vehicle	e you were in:		
a. Vehicle Type:			
Car	Van	Station Wagon	Pickup
Truck	Bus	Other:	1
b. Vehicle Size:			
Subcompact	Compact	Mid-Size	Full-Size
Subcompact Mini			1·uii-5ize
	Light	Other:	
c. How did this vehicle strike the			
		From Left	Rear Ended
Sideswiped on Right			Other:
d. What damage did this vehicle	e sustain?		
Minimal	Moderate	Extensive	Totaled
Unsure	Other:		
3. Describe other vehicles to strike	vehicle von were in:		
Vehicle Type:	How it struck:		
Vehicle Type. Vehicle Size:			
venicie size:	Damage:		
4. Were traffic citations issued as r No Citations IssuedDriver of other Vehicle		Unsure u were in	
D. CONDITIONS AT TIME OF ACCI	DENT		
1. What time of day did the acciden	nt occur?		
Daylight	Dawn	Dusk	Night
Other:			_
2. What was the condition of the ro	oad?		
Dry	Damp	Wet	Snow Covered
Icy	Other:	,,,,ee	
icy	oulci.		
3. Visibility:			
	a a4.		
a. What was the visibility at imp		D	0.1
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 accid	ent•		
Accident a complete su		Aware of impendin	a collision
		Aware or impendin	S COMMONDIA
And braced for impact			
A.D. (D. 1			
2. Foot on Brake Pedal:			
 a. Was you foot on brake peda 		YesNo	
 b. Was it knocked off pedal by 	impact:	Yes No	

i. Were you wearing a restraint belt? ii. What type of restrain belt were you wearing? _Shoulder-lap BeltShoulder BeltShoulder-lap BeltShoulder-lap BeltShoulder-lap BeltShoulder-lap BeltShoulder-lap BeltShoulder-lap Belt	3. Use of Restraints: a. Restraint Belts:				
ii. What type of restrain belt were you wearing? Shoulder-lap Belt		t helt?	Ves	No	
			1 C3	110	
b. Headrest i. Was vehicle equipped with headrest: 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: 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 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 Window Left Window Headrest Ceiling Console Shift Lever Console Left Side Door Armrest Right Window Left Window Headrest Ceiling Console Shift Lever			Lap Bel	t	
ii. What position was headrest in: LowMiddleHighDon't Know c. Airbags i. Was vehicle equipped with air bags?YesNo					
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b. What direction was your body thrown: Forward/Backward	Straight	Slouched Forward	Rotated	Right	Rotated Left
	Don't Recall	Other:			
	h What direction was your body	thrown			
Across VehicleOther: c. Did you receive any bleeding cuts? If so, where?			Sideway	1 S	
	Across Vehicle	Outside Vehicle	Under V	ehicle	
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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 Left Window Left Window Left Side Door Armrest Right Window Left Window Headrest Ceiling Console Shift Lever	Don't Recall	Other:			
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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			Sideway	'S	
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Left Side DoorArmrestRight WindowLeft WindowL		Dashboard	Windsh	ield	Right Side Door
Headrest Ceiling Console Shift Lever					
<u></u>					
				_	

Steering Wheel	Dooleleaned	Windows 1.1	Diale Cide Deen
	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:	D 11 1	XXV: 11:11	D: 1. G: 1. D
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
110441030			
Front Seat Did your body strike any other DITIONAL INFORMATION In your own words please descri	•		Other: Etc.
Front Seat Did your body strike any other DITIONAL INFORMATION	objects:		_
Front Seat Did your body strike any other DITIONAL INFORMATION	objects:		_
Front Seat Did your body strike any other DITIONAL INFORMATION	objects:		_
Front Seat Did your body strike any other DITIONAL INFORMATION	objects:		_
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Front Seat Did your body strike any other DITIONAL INFORMATION	objects:		_
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