



PRINT YOUR FULL NAME _____

A. VEHICLE YOU WERE IN

- 1. **Date of Accident:** _____
- 2. **Vehicle Type?**
Car Pickup Van Truck Station Wagon Bus Other _____
- 3. **Vehicle Size?**
Subcompact Full-Size Compact Mini Light Other _____
- 4. **What was YOUR location in the vehicle?**
Driver Front Passenger Rear Passenger
PASSENGER LOCATION: Front Passenger Rear Passenger

5. What was the vehicle you were in doing?
MARK ONLY ONE ANSWER FOR THE ABOVE QUESTION

- A. **Vehicle 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 ___MPH Accelerating Other _____
- D. **Vehicle doing other...**
Explain: _____

6. What damage did the vehicle you were in sustain?
Minimal Moderate Extensive Totaled Unsure Other _____

B. IF OTHER VEHICLES INVOLVED IN ACCIDENT

- 1. **First vehicle**
 - A. **Vehicle Type?**
Car Pickup Van Truck Station Wagon Bus Other _____
 - B. **Vehicle Size?**
Subcompact Full-Size Compact Mini Mid-Size Light Other _____
 - C. **How did this vehicle impact with your vehicle?**

 - D. **What damage did this vehicle sustain?**
Minimal Moderate Extensive Totaled Unsure Other _____

- 2. **Second vehicle**
 - A. **Vehicle Type?**
Car Pickup Van Truck Station Wagon Bus Other _____
 - B. **Vehicle Size?**
Subcompact Full-Size Compact Mini Mid-Size Light Other _____
 - C. **How did this vehicle impact with your vehicle?**

 - D. **What damage did this vehicle sustain?**
Minimal Moderate Extensive Totaled Unsure Other _____

NOTE: This questionnaire will allow you to describe your automobile accident in detail. Please complete it carefully as the information will assist us in evaluating and documenting your condition.

Patient or Guardian Signature: _____ **Date:** _____

CONFIDENTIAL

AUTOMOBILE ACCIDENT QUESTIONNAIRE



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C. CONDITIONS AT TIME OF ACCIDENT

1. What time of day did the accident occur?

Dawn Day AM Day PM Dusk Night Other _____

2. What was the condition of the road?

Dry Damp Wet Snow-covered Icy Sandy/Gravel Other _____

3. Visibility

A. What was the visibility at impact?

Good Fair Poor Other _____

B. If visibility was poor, why?

Clear Cloudy Drizzling Foggy Rainy Snowing Stormy Sunny Other _____

D. AT MOMENT OF IMPACT

1. Were you prepared for the accident?

Accident a complete surprise Aware of impending collision Braced for impact

2. Foot on the brake pedal

A. Was your foot on the pedal at impact?

Yes No

B. Was it knocked off pedal by impact

Yes No

3. Use of restraints

A. Were you wearing a restraint belt?

Yes No

B. What type of restraint belt were you wearing?

Shoulder-Lap Belt Shoulder Belt Lap Belt

C. Was vehicle equipped with headrest?

Yes No

D. What position was the headrest in?

Low Middle High Don't Know

E. Was vehicle equipped with airbags?

Yes No Unsure

F. Did airbags deploy?

Yes No

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 To Right To Left About the vehicle
Under the vehicle Outside the vehicle Don't recall Other _____

C. What did your body strike in the vehicle?

Door Airbag Steering Wheel Windshield Rearview mirror
Arm rest Another Passenger Other _____

D. Did objects inside the vehicle become displaced?

Yes No If so, what? _____

5. Your Head & Neck

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

Straight Tilted forward Rotated Right
Rotated Left Don't Recall Other _____

B. Through what motions were your head/neck pitched?

Forward/Backward Backward/Forward
Sideways Don't Recall Other _____

Patient or Guardian Signature: _____

Date: _____



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E. POST ACCIDENT

1. Initial Reaction

Shaken Upset Nervous Confused Frightened Dazed Distressed Dizzy Lightheaded Weak Other

A. Where did pain occur?

B. Did you lose consciousness?

Yes No Unsure

C. Type of emergency care?

Bandaging Bracing CPR
Neck Collar Splinting

D. Where did you go immediately?

Work Home School Hospital
Clinic Doctor's office

E. Who drove you?

F. Where were cuts located?

2. When did your pain begin?

Immediately _____ Hours _____ Days

F. POST ACCIDENT TREATMENT

A. Initial hospital / doctor's visit date _____

B. Date of discharge? _____

C. Name of doctor / hospital? _____

D. Examining Physician? _____

E. Were you admitted? YES NO

F. X-rays taken of what? _____

G. ADDITIONAL INFORMATION

E. PAIN SCALE

Present Complaints:

Pain Scale Severity

Neck	0	1	2	3	4	5	6	7	8	9	10
Mid-Back	0	1	2	3	4	5	6	7	8	9	10
Low-Back	0	1	2	3	4	5	6	7	8	9	10
Hips	0	1	2	3	4	5	6	7	8	9	10
Arms	0	1	2	3	4	5	6	7	8	9	10
Legs	0	1	2	3	4	5	6	7	8	9	10
Other	0	1	2	3	4	5	6	7	8	9	10
Other	0	1	2	3	4	5	6	7	8	9	10

Patient or Guardian Signature: _____

Date: _____