Auto Accident Questionnaire

Name: ______________________________

1. What was the date of the accident? ___________________________

2. At what time did the accident occur? ____________________________

3. How many vehicles were involved in the accident?___________________

4. In dollar amount, what was the estimated damage to the vehicle you were in? _______________

5. What road were you on when the accident occurred? ___________________________________

6. What direction were you travelling in: (circle one)
   North West East Northwest Southwest
   Northeast Southeast

7. What city were you in when the accident happened? ___________________________________

8. What state were you in when the accident happened? ________________________________

9. Please choose the primary type of impact: (circle one)
   The vehicle was rear ended
   The vehicle hit another from behind
   The vehicle was hit on driver's side
   The vehicle was hit on the passenger's side
   The vehicle was hit head on
   Other ___________________________________

10. Did you know the accident was coming?

11. Which of the following was your vehicle doing at the time of the impact? (circle one)
    Slowing down
    Stopped
    Moving at a steady pace
    Gaining speed

12. What did the vehicle do immediately after the accident? (circle one)
    Hit a guardrail
    Hit a tree
    Was run off the run
    Rolled over
    Other ____

13. Where was the patient sitting in the vehicle during the impact? (circle one)
    Driver's seat
    Front passenger
    Left rear passenger
    Right rear passenger
    Rear middle passenger
    Other ______________________________________

14. During and after the crash, what happed to your vehicle? (circle all that apply)
    Kept going straight
    Kept going straight, hitting a car in front
    Spun around
    Spun around and hit a stationary object
    Was hit by another vehicle
    Other ____

15. What type of vehicle were you in? (circle one)
    - Subcompact car
    - Compact car
    - Mid-sized car
    - Full-sized car
    - Truck
    - SUV
    - Minivan
    - Van
    - A larger than 1-ton vehicle
    - Other ______________________________

16. Did you lose consciousness during the accident? (circle one) Yes No

17. How was your head positioned during the accident? (i.e. facing forward, downward, turned)
    ____

18. How was your torso positioned during the accident? _____________________________________

19. How were your hands positioned during the accident? _____________________________________

20. Did your head hit anything during the accident? No Yes, please describe: ________
    ____

21. Did your shoulders hit anything during the accident? No Yes, please describe: ________
    ____

22. Did your face hit anything during the accident? No Yes, please describe: ________
    ____

23. Did your neck hit anything during the accident? No Yes, please describe: ________
    ____

24. Did your chest hit anything during the accident? No Yes, please describe: ________
    ____

25. Did your hips hit anything during the accident? No Yes, please describe: ________
    ____

26. Did your knees hit anything during the accident? No Yes, please describe: ________
    ____

27. Did your feet hit anything during the accident? No Yes, please describe: ________
    ____

28. What kind of headrest was in your vehicle?
    - Movable fixed headrest
    - No movable fixed headrest
    - No headrest

29. Where was the headrest positioned on your head during the accident?
    - Top of back of head
    - Middle height of back of head
    - Lower portion of back of head
    - Level of back of neck
    - Level of shoulder blades

30. Did you have your seatbelt on during the accident? Yes No Can't remember

31. What type of seatbelt were you wearing? (If applicable)
    - Shoulder strap
    - Lap seatbelt
    - Baby car seat
    - Booster seat

32. Did you slide out of your seatbelt during the accident? _____________________________

33. What was damaged in the vehicle? (Circle all that apply)
    - Windshield
    - Steering wheel
    - Dashboard
    - Seat frame
    - Side window
    - Rear window
    - Mirror
    - Knee Bolster
    - Trunk
    - Rear bumper
    - Front bumper
    - Back right door
    - Front left door
    - Front right door
    - Back left door
    - Other ____________________________
    - None

34. Choose the items that dented inward (if applicable).
    - Floorboards
    - Side door
    - Dashboard
    - None
    - Other _____________

35. Choose doors that wouldn't open as a result of the accident? (If applicable)
    Front left   Front right   Rear left   Rear right   None
36. Did you go to the hospital? If no, why (and do not answer 38-44)
    ____
37. How did you get to the hospital? (i.e. ambulance, drove yourself, walked, driven by someone else)
    ____
38. What was the name of the hospital that you went to? ___________________________________
39. Were you hospitalized over night? ______________________________
40. Circle if you were prescribed any of the following at hospital.
    Pain medications   Muscle relaxers   Other ___________________________
41. Did you receive any stitched for cuts at the hospital? If so, where? _________________________
42. Did you receive any of the following braces or supports at the hospital? (circle all that apply)
    Cervical collar   Back brace   Not applicable   Other ____________________
43. Were x-rays taken at the hospital? If yes, which area?
    Skull   Pelvis   Foot   Neck   Hips
    Shoulder   Mid back   Leg   Arm   Low back
    Knee   Other __________________________
44. Was an MRI performed? If yes, which area?
    Skull   Pelvis   Foot   Neck   Hips
    Shoulder   Mid back   Leg   Arm   Low back
    Knee   Other __________________________
45. Did you receive any other special imaging? If yes, please describe and circle which area.
    ____
    Skull   Pelvis   Foot   Neck   Hips
    Shoulder   Mid back   Leg   Arm   Low back
    Knee   Other __________________________

Before signing this document, verify that the content you are signing is correct.

X ______________________________
Signature

____
Date