Auto Accident Questionnaire Form

Patient Name: ________________________________ File No.: ____________________

Date of Accident:_______________ Time of Accident:_______________

During the Motor Vehicle Accident…

1. The accident occurred during [ ]dawn [ ]daylight [ ]dusk [ ]night.
2. Were you the [ ]driver [ ]front seat passenger [ ]left or [ ]right rear seat passenger? Other____
3. Were you using seatbelts? [ ]Yes [ ]No. Were you using a shoulder harness? [ ]Yes [ ]No.
4. Make, model, year of your vehicle_______________________________
5. Did the airbags deploy? [ ]Yes [ ]No.
6. Was your seat equipped with a stationary, adjustable headrest? [ ]Yes [ ]No.
7. Did you anticipate the accident? [ ]Yes [ ]No.
8. The road condition was [ ]dry [ ]damp [ ]wet.
9. What direction was your head facing during the accident? [ ]straight forward [ ]right [ ]left Other____
10. Was your foot on the brake at the time of impact? [ ]Yes [ ]No. Was your foot knocked off the brake at the time of impact? [ ]Yes [ ]No.
11. Were you knocked unconscious? [ ]Yes [ ]No. If yes, for how long?_____
12. Were you struck from [ ]behind, [ ]head on collision (front), [ ]broadside [ ]right [ ]left, [ ]multi-car collision, [ ]no collision. Other____
13. Was your vehicle stopped? []Yes [ ]No. If not, how fast was it going? ________MPH
14. What was your vehicle doing immediately prior to impact (i.e. changing lanes, driving through an intersection)?____
15. What was the estimated damage to your vehicle?_______________________

16. Was another vehicle involved? [ ]Yes [ ]No. Number of other vehicles _____

    Which vehicle hit the other? ____

17. Make, model, year of car(s) that struck you.___________________________

18. What was the other vehicles point of impact (i.e. front bumper, passenger's side, etc.).

    ____

19. What was the other vehicle doing immediately prior to impact (i.e. changing lanes, driving through an intersection)?_________________________________

20. How fast was the other vehicle traveling? ________MPH

21. Were you treated by paramedics? [ ]Yes [ ]No________________________

22. Were the police notified? [ ]Yes [ ]No. Was a report made? [ ]Yes [ ]No

23. Where did you go after the accident? (home, hospital, etc.)_______________

Since the accident have you experienced any of the following: Please check symptoms that you are presently experiencing that have occurred

[ ] Headache	[ ] Irritability	[ ] Numbness in Toes	[ ] Face Flushed	[ ] Feet Cold
[ ] Neck Pain	[ ] Chest Pain	[ ] Shortness of Breath	[ ] Buzzing in Ears	[ ] Hands Cold
[ ] Neck Stiff	[ ] Dizziness	[ ] Fatigue	[ ] Loss of Balance	[ ] Stomach Upset
[ ] Sleeping Difficulty	[ ] Head Seems too Heavy	[ ] Depression	[ ] Fainting	[ ] Constipation
[ ] Low Back Pain	[ ] Pins & Needles in Arms	[ ] Lights Bother Eyes	[ ] Loss of Smell	[ ] Cold Sweats
[ ] Nervousness	[ ] Pins & Needles in Legs	[ ] Loss of Memory	[ ] Loss of Taste	[ ] Fever
[ ] Tension	[ ] Numbness in Fingers	[ ] Ears Ring	[ ] Diarrhea	[ ] _____________

Symptoms other than above ____

Other pertinent information ____

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_________________________________   __________________

Signature (Patient or Guardian)   *Date*