

Auto Accident Questionnaire

Patient Name: _____ Date: _____

1. What was the date of the accident? _____
2. What time did the accident occur? _____
3. How many vehicles were involved in the accident? _____
4. What was the estimated damage to the vehicle you were in? _____
5. What state did the accident occur in? _____
6. What city did the accident occur in? _____
7. What street or intersection were you on when the accident occurred? _____
8. What direction were you traveling in? _____
9. What type of impact was the auto accident? _____
10. Did your vehicle hit anything after the accident? no yes, please describe _____

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11. Where were you sitting in the vehicle during the accident? _____
 12. Did you know the accident was coming? _____
 13. What type of vehicle were you in? _____
 14. What type of vehicle impacted yours? _____
 15. At the time of the impact, how fast was your vehicle moving? _____
 16. At the time of impact, how fast was the other vehicle moving? _____
 17. During and after the crash what happened to your vehicle? (check all that apply)
 - kept going straight
 - spun around
 - kept going straight hitting a car in front
 - spun around and hit a stationary object
 - was hit by another vehicle
 - hit a stationary object

18. Did you lose consciousness during the accident? yes no
19. How was your head positioned during the accident? _____
20. How was your torso positioned during the accident? _____
21. How were your hands positioned during the accident? _____
22. Did your head hit anything during the accident? no yes, please describe _____

23. Did your face hit anything during the accident? no yes, please describe _____

24. Did your shoulders hit anything during the accident? no yes, please describe _____

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25. Did your neck hit anything during the accident? no yes, please describe _____

26. Did your chest hit anything during the accident? no yes, please describe _____

27. Did your hips hit anything during the accident? no yes, please describe _____

28. Did your knees hit anything during the accident? no yes, please describe _____

29. Did your feet hit anything during the accident? no yes, please describe _____

30. What kind of headrest was in your vehicle?
 movable fixed headrest non-movable fixed headrest no headrest

31. Where was the headrest positioned on your head? _____

32. Did you have your seatbelt on during the accident? no yes

33. Did you slide out of your seatbelt during the accident? no yes

34. What was damaged in your vehicle? (Check all that apply)

<input type="checkbox"/> windshield	<input type="checkbox"/> side window	<input type="checkbox"/> trunk	<input type="checkbox"/> mirror
<input type="checkbox"/> steering wheel	<input type="checkbox"/> rear window	<input type="checkbox"/> front left door	<input type="checkbox"/> knee bolster
<input type="checkbox"/> dashboard	<input type="checkbox"/> rear bumper	<input type="checkbox"/> front right door	<input type="checkbox"/> back right door
<input type="checkbox"/> seat frame	<input type="checkbox"/> front bumper	<input type="checkbox"/> back left door	<input type="checkbox"/> completely totaled

35. Choose the items that dented inward
 floorboards side door dashboard

36. Choose the doors that would not open as a result of the accident
 front left front right rear left rear right

37. Did you go to the hospital? If no, why and do not answer 38-43

38. How did get to the hospital? _____

39. What was the name of the hospital? _____

40. Were you hospitalized over night? no yes, how long _____

41. Circle what you were prescribed at the hospital:
 pain medication muscle relaxors neck brace

42. Did you receive any stitches for any cuts at the hospital? no yes, where _____

43. Were x rays taken at the hospital? no yes, which area was taken? _____