

# AUTOMOBILE ACCIDENT QUESTIONNAIRE

Patient's Name: \_\_\_\_\_

Today's Date: \_\_\_\_\_

Date of Accident: \_\_\_\_\_

## THE FOLLOWING QUESTIONS PERTAIN TO YOU AND THE VEHICLE YOU WERE IN:

### Vehicle type:

- Car       Pickup  
 Van       Truck  
 Station Wagon  
 Other \_\_\_\_\_

### Vehicle size:

- Subcompact       Full-size  
 Compact       Mini  
 Bus       Mid-size       Light  
 Heavy       Other \_\_\_\_\_

### Your position in the vehicle:

- Driver  
 Passenger ----- Location-----  Left       Middle       Right  
 Other \_\_\_\_\_       Front Passenger       Rear Passenger       Third Seat (rear)

### Speed of your vehicle:

- Stopped       Moving Moderately  
 Parked       Moving Fast  
 Slowing       Moving at apprx \_\_\_\_\_MPH  
 Moving Slowly

### Why Vehicle was slowed or stopped:

- Traffic Signal       Parking  
 Pedestrian       Traffic  
 Stop Sign       Busy Intersection

### Collision Type:

- Driver Side Impact       Head On Collision  
 Passenger Side Impact       Rear Impact  
 Front Impact       Pedestrian Incident

## THE FOLLOWING QUESTIONS CONCERN THE OTHER VEHICLE INVOLVED IN THE ACCIDENT:

### Vehicle type:

- Car       Pickup  
 Van       Truck  
 Station Wagon  
 Other \_\_\_\_\_

### Vehicle size:

- Subcompact       Full-size  
 Compact       Mini  
 Bus       Mid-size       Light  
 Heavy       Other \_\_\_\_\_

## CONDITIONS AT THE TIME OF THE ACCIDENT:

### Time of day:

- Full daylight  
 Dawn  
 Dusk  
 Night

### Road Conditions:

- Dry  
 Damp  
 Wet  
 Snow covered  
 Ice covered  
 Patchy Ice/Snow

### Visibility:

- Excellent  
 Good  
 Fair  
 Poor

### Visibility compromised by:

- Brightness  
 Darkness  
 Rain  
 Snow  
 Fog  
 Traffic

## THE FOLLOWING QUESTIONS CONCERN THE MOMENT OF IMPACT OF THE ACCIDENT:

### Were you... \_\_\_\_\_

- Totally unaware that the accident was impending  
 Aware that the accident was impending  
 Aware that the accident was impending and braced for it

### Restraints: (check all that apply)

- Seat belt  
 Shoulder harness  
 No restraints

If you were the driver of the vehicle, was your foot on the brake pedal?  Yes  No  Knocked off by impact

### Was the air bag deployed? \_\_\_\_\_

- Car not equipped with air bag  
 Air bag deployed  
 Air bag not deployed

### What position was YOUR headrest in? \_\_\_\_\_

- High position  
 Middle position  
 Low position

**Position of YOUR head at time of impact?**

- Facing straight ahead
- Tilted forward
- Rotated to the left
- Rotated to the right

**Was your head thrown...?**

- Backward and then forward
- Forward then backward
- To the left       To the left then the right
- To the right       To the right, then the left

**Position of Your body at time of impact?**

- Straight
- Tilted forward
- Rotated to the left
- Rotated to the right

**Was your body thrown...?**

- Backward and then forward
- Forward then backward
- To the left       To the left then the right
- To the right       To the right, then the left
- Across the vehicle
- Outside the vehicle       Under the vehicle

**Damage to vehicle YOU were in:**

- Incurred minimal damage
- Incurred moderate damage
- Incurred severe damage
- Was totalled
- Not known

**Citations:**

- None issued
- Yourself
- Driver of vehicle patient was a passenger of
- Driver of other vehicle
- Not sure

*AS A RESULT OF THE FORCE OF THE COLLISION, WHICH OBJECTS IN THE VEHICLE DID YOUR BODY STRIKE?*

**Head**

- Steering wheel
- Dashboard
- Windshield
- Armrest
- Headrest
- Rear view mirror
- Left door
- Right door
- Left window
- Right window
- Console
- Gear shift
- Front seat
- Backseat

**Left Arm**

- Steering wheel
- Dashboard
- Windshield
- Armrest
- Headrest
- Rear view mirror
- Left door
- Right door
- Left window
- Right window
- Console
- Gear shift
- Front seat
- Backseat

**Right Arm**

- Steering wheel
- Dashboard
- Windshield
- Armrest
- Headrest
- Rear view mirror
- Left door
- Right door
- Left window
- Right window
- Console
- Gear shift
- Front seat
- Backseat

**Torso**

- Steering wheel
- Dashboard
- Windshield
- Armrest
- Headrest
- Rear view mirror
- Left door
- Right door
- Left window
- Right window
- Console
- Gear shift
- Front seat
- Backseat

**Left Leg**

- Steering wheel
- Dashboard
- Windshield
- Armrest
- Headrest
- Rear view mirror
- Left door
- Right door
- Left window
- Right window
- Console
- Gear shift
- Front seat
- Backseat

**Right Leg**

- Steering wheel
- Dashboard
- Windshield
- Armrest
- Headrest
- Rear view mirror
- Left door
- Right door
- Left window
- Right window
- Console
- Gear shift
- Front seat
- Backseat

THE FOLLOWING QUESTIONS CONCERN THE TIME PERIOD IMMEDIATELY FOLLOWING THE ACCIDENT:

**Did you lose consciousness?**

- Yes
- No

**Immediately following the accident, did you feel...?**

- Dizzy
- Dazed
- Disoriented
- Weak
- Nervous
- Nauseated

**Were you able to walk unaided?**

- Yes
- No

**Where did you go...?**

- Drove home
- Was driven home
- Drove to hospital
- Was driven to hospital
- Taken to hospital via ambulance
- Drove to work
- Was driven to work
- Drove to school
- Was driven to school

**Next day discomfort...?**

- increased
- decreased
- same

**Did your major complaints exist before the accident?**

- Yes
- No

**In what areas did you IMMEDIATELY feel pain?**

- Head  Shoulder  Left  Right  Hip  Left  Right
- Neck  Arm  Left  Right  Thigh  Left  Right
- Upper back  Elbow  Left  Right  Knee  Left  Right
- Mid back  Wrist  Left  Right  Calf  Left  Right
- Ribs  Hand  Left  Right  Ankle  Left  Right
- Chest  Fingers  Left  Right  Foot  Left  Right
- Abdomen  Buttock  Left  Right  Toes  Left  Right
- Low Back  Pelvis

**In what areas did you experience lacerations (cuts)?**

- Head  Shoulder  Left  Right  Hip  Left  Right
- Neck  Arm  Left  Right  Thigh  Left  Right
- Upper back  Elbow  Left  Right  Knee  Left  Right
- Mid back  Wrist  Left  Right  Calf  Left  Right
- Ribs  Hand  Left  Right  Ankle  Left  Right
- Chest  Fingers  Left  Right  Foot  Left  Right
- Abdomen  Buttock  Left  Right  Toes  Left  Right
- Low Back  Pelvis

**At the hospital, what areas were x-rayed?**

- Head  Shoulder  Left  Right  Hip  Left  Right
- Neck  Arm  Left  Right  Thigh  Left  Right
- Upper back  Elbow  Left  Right  Knee  Left  Right
- Mid back  Wrist  Left  Right  Calf  Left  Right
- Ribs  Hand  Left  Right  Ankle  Left  Right
- Chest  Fingers  Left  Right  Foot  Left  Right
- Abdomen  Buttock  Left  Right  Toes  Left  Right
- Low Back  Pelvis

**Where did you experience pain on the day FOLLOWING the accident?**

- Head  Shoulder  Left  Right  Hip  Left  Right
- Neck  Arm  Left  Right  Thigh  Left  Right
- Upper back  Elbow  Left  Right  Knee  Left  Right
- Mid back  Wrist  Left  Right  Calf  Left  Right
- Ribs  Hand  Left  Right  Ankle  Left  Right
- Chest  Fingers  Left  Right  Foot  Left  Right
- Abdomen  Buttock  Left  Right  Toes  Left  Right
- Low Back  Pelvis

Patient's Signature: \_\_\_\_\_