

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 Bus
 Other _____

Vehicle Size:

- Subcompact Full-size
 Compact Mini
 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 Traffic Signal Parking
 Parked Moving Fast Pedestrian Traffic
 Slowing Moving Slowly Stop Sign Busy Intersection
 Moving at approx ____ MPH

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 Bus
 Other _____

Vehicle Size:

- Subcompact Full-size
 Compact Mini
 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 ACCIDENT:

Were you...

- Totally unaware that the accident was impending
 Aware that the accident was impending
 Aware that the accident was impending & 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
 High position

Position of your head at time of impact?

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

Position of your body at time of impact?

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

Damage to vehicle you were in:

- Incurred minimal damage
- Incurred moderate damage
- Incurred severe damage
- Was totaled
- Unknown

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 to the left

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

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?

- | | | | | | | |
|-------------------------------------|---------------------------------|-------------------------------|--------------------------------|-------|-------------------------------|--------------------------------|
| <input type="checkbox"/> Head | Shoulder | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Hip | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Neck | Arm | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Thigh | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Upper back | Elbow | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Knee | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Mid back | Wrist | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Calf | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Ribs | Hand | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Ankle | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Chest | Fingers | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Foot | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Abdomen | Buttock | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Toes | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Low back | <input type="checkbox"/> Pelvis | | | | | |

In what areas did you experience lacerations (cuts)?

- | | | | | | | |
|-------------------------------------|---------------------------------|-------------------------------|--------------------------------|-------|-------------------------------|--------------------------------|
| <input type="checkbox"/> Head | Shoulder | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Hip | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Neck | Arm | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Thigh | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Upper back | Elbow | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Knee | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Mid back | Wrist | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Calf | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Ribs | Hand | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Ankle | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Chest | Fingers | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Foot | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Abdomen | Buttock | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Toes | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Low back | <input type="checkbox"/> Pelvis | | | | | |

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

- | | | | | | | |
|-------------------------------------|---------------------------------|-------------------------------|--------------------------------|-------|-------------------------------|--------------------------------|
| <input type="checkbox"/> Head | Shoulder | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Hip | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Neck | Arm | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Thigh | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Upper back | Elbow | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Knee | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Mid back | Wrist | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Calf | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Ribs | Hand | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Ankle | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
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| <input type="checkbox"/> Abdomen | Buttock | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Toes | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Low back | <input type="checkbox"/> Pelvis | | | | | |

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

- | | | | | | | |
|-------------------------------------|---------------------------------|-------------------------------|--------------------------------|-------|-------------------------------|--------------------------------|
| <input type="checkbox"/> Head | Shoulder | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Hip | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Neck | Arm | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Thigh | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
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| <input type="checkbox"/> Abdomen | Buttock | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Toes | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Low back | <input type="checkbox"/> Pelvis | | | | | |

Patient's Signature: _____

FIRST DOCTOR/HOSPITAL/CLINIC

Yes No Were you hospitalized as a result of this accident/ If Yes, where: _____

Doctor 1 Name: _____ Date of first visit: _____

Yes No Were you examined? Yes No Were X-rays taken?

What diagnosis did the doctor give you? _____

Yes No Were you given treatment? If yes, what type? _____
What benefits did you receive from this treatment? _____

Date of last treatment? _____

Yes No Did the doctor refer you to another health professional? If yes, to whom and for what? _____

Yes No Did you follow the doctor's recommendation? If no, why not? _____

SECOND DOCTOR/CLINIC

Doctor 2 Name: _____ Date of first visit: _____

Yes No Were you examined? Yes No Were X-rays taken?

What diagnosis did the doctor give you? _____

Yes No Were you given treatment? If yes, what type? _____
What benefits did you receive from this treatment? _____

Date of last treatment? _____

PRIOR SIMILAR SYMPTOMS

Yes No Did you have any physical complaints just before the accident? If yes, please describe in detail: _____

Yes No Have you ever had any prior injuries, accidents, diseases, or treatment to the area of your body now affected? If yes, what part was previously injured? _____

Date previously injured? _____
Describe previous injury: _____

Yes No Were you treated? By whom? _____
Date treatment began: _____ Date treatment ended: _____

The last date you felt pain or problems from that previous injury: _____

PLEASE SEE PAGE 5 FOR JOB DESCRIPTION

JOB DESCRIPTION

In terms of an 8-hour workday: **Occasionally**=33%, **Frequently**=34 to 64%, **Continuously**=67 to 100 %

In a typical 8 – hour workday, I (circle the number of hours of activity):

Sit	1	2	3	4	5	6	7	8	Hours
Stand	1	2	3	4	5	6	7	8	Hours
Walk	1	2	3	4	5	6	7	8	Hours

On the job, I perform the following activities:

	Not at all	Occasionally	Frequently	Continuously
Bend/Stoop	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Squat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crawl	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climb	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reach Above	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shoulder Level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crouch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kneel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Balancing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pulling/Pushing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

On the job, I lift:

	Not at all	Occasionally	Frequently	Continuously
Up to 10 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11 to 24 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25 to 34 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
35 to 50 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
51 to 74 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
75 to 100 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- Yes No Are you required to bend over while doing any lifting?
- Yes No Are your feet used in repetitive movements, such as operating foot controls?

Do you use your hands for repetitive actions such as:

	Simple Grasping	Firm Grasping	Fine Manipulating
Right Hand	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Left Hand	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

- Yes No Are you required to work at unprotected heights? If yes, describe: _____
- Yes No Are you required to be around moving machinery? If yes, please describe: _____
- Yes No Are you exposed to marked changes in temperature and humidity? If yes, please describe: _____
- Yes No Are you required to drive automotive equipment? If yes, please describe: _____
- Yes No Are you exposed to dust, flames, and/or gasses/ If yes, please describe: _____

Please list any additional comments: _____

Patients Signature: _____ **Date:** _____