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

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

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 totaled
☐ Unknown

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

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

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

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

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

Right Leg
☐ Steering wheel ☐ Right door
☐ Dashboard ☐ Left window
☐ Windshield ☐ Right window
☐ Armrest ☐ Console
☐ Headrest ☐ Gear shift
☐ Rear view mirror ☐ Front seat
☐ Left door ☐ 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 ☐ Weak
☐ Dazed ☐ Nervous
☐ Disoriented ☐ Nauseated

Were you able to walk unaided?

☐ Yes
☐ No

Where did you go?

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

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 you 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: ____

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	☐	☐	☐	☐
Squat	☐	☐	☐	☐
Crawl	☐	☐	☐	☐
Climb	☐	☐	☐	☐
Reach Above	☐	☐	☐	☐
Shoulder Level	☐	☐	☐	☐
Crouch	☐	☐	☐	☐
Kneel	☐	☐	☐	☐
Balancing	☐	☐	☐	☐
Pulling/Pushing	☐	☐	☐	☐

On the job, I lift:	**Not at all**	**Occasionally**	**Frequently**	**Continuously**
Up to 10 pounds	☐	☐	☐	☐
11 to 24 pounds	☐	☐	☐	☐
25 to 34 pounds	☐	☐	☐	☐
35 to 50 pounds	☐	☐	☐	☐
51 to 74 pounds	☐	☐	☐	☐
75 to 100 pounds	☐	☐	☐	☐

☐ 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	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Left Hand	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ 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, pleas describe: _______________

____

☐ Yes ☐ No Are you exposed to dust, flames, and/or gasses/ If yes, please describe: _______________

____

Pleas list any additional comments: ____

____

____

Patients Signature: ____________________________________ **Date:** ____________________