

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 Van Station Wagon Pickup
 Truck Bus Other _____

Vehicle Size:

- Subcompact Compact Mid-Size Heavy
 Full-size Light Mini Other _____

Your Position in the Vehicle:

- Driver
 Passenger - Location Left Middle Right
 Front Passenger Rear Passenger Third Seat (Rear)
 Other _____

Speed of Your Vehicle:

- Stopped Parked Slowing
 Moving Slowly Moving Moderately
 Moving Fast Moving at Approx. _____ MPH

Why Vehicle Was Slowed or Stopped:

- Traffic Signal Pedestrian Stop Sign
 Parking Traffic Busy Intersection

Collision Type:

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

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

Vehicle Type:

- Car Van Station Wagon Pickup
 Truck Bus Other _____

Vehicle Size:

- Subcompact Compact Mid-Size Heavy
 Full-size Light Mini 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 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

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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 totalled
- Not known

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

Was your body thrown . . . ?

- Backward and then forward
- Forward and 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

AUTOMOBILE ACCIDENT QUESTIONNAIRE

THE FOLLOWING QUESTIONS CONCERN THE 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 | <input type="checkbox"/> Shoulder | <input type="checkbox"/> Left | <input type="checkbox"/> Right | <input type="checkbox"/> Hip | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Neck | <input type="checkbox"/> Arm | <input type="checkbox"/> Left | <input type="checkbox"/> Right | <input type="checkbox"/> Thigh | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Upper back | <input type="checkbox"/> Elbow | <input type="checkbox"/> Left | <input type="checkbox"/> Right | <input type="checkbox"/> Knee | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Mid back | <input type="checkbox"/> Wrist | <input type="checkbox"/> Left | <input type="checkbox"/> Right | <input type="checkbox"/> Calf | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Ribs | <input type="checkbox"/> Hand | <input type="checkbox"/> Left | <input type="checkbox"/> Right | <input type="checkbox"/> Ankle | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Chest | <input type="checkbox"/> Fingers | <input type="checkbox"/> Left | <input type="checkbox"/> Right | <input type="checkbox"/> Foot | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Abdomen | <input type="checkbox"/> Buttock | <input type="checkbox"/> Left | <input type="checkbox"/> Right | <input type="checkbox"/> 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)?

- | | | | | | | |
|-------------------------------------|-----------------------------------|-------------------------------|--------------------------------|--------------------------------|-------------------------------|--------------------------------|
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| <input type="checkbox"/> Low Back | | | | | | |
| <input type="checkbox"/> Pelvis | | | | | | |

At the hospital, what areas were x-rayed?

- | | | | | | | |
|-------------------------------------|-----------------------------------|-------------------------------|--------------------------------|--------------------------------|-------------------------------|--------------------------------|
| <input type="checkbox"/> Head | <input type="checkbox"/> Shoulder | <input type="checkbox"/> Left | <input type="checkbox"/> Right | <input type="checkbox"/> Hip | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
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| <input type="checkbox"/> Low Back | | | | | | |
| <input type="checkbox"/> Pelvis | | | | | | |

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

- | | | | | | | |
|-------------------------------------|-----------------------------------|-------------------------------|--------------------------------|--------------------------------|-------------------------------|--------------------------------|
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| <input type="checkbox"/> Pelvis | | | | | | |

Patient's Signature: _____ 3