

Auto Accident Questionnaire

Patient _____ **Date:** ___/___/___

What was the date and time of accident? ___/___/___ ___:___ AM/PM

How many vehicles were involved in the accident? _____

What was the estimated damage to the vehicle you were in? _____

Where did the accident occur in? _____

Street

City

State

What direction were you travelling in? _____

What type of impact was the auto accident? _____

Did your vehicle hit anything after the accident? YES/NO If yes, please describe: _____

Where were you sitting in the vehicle during the accident? _____

Did you know the accident was coming? YES/NO

What is the make & model of the vehicle you were in? _____

What is the make & model of the vehicle that impacted you? _____

What speed were you going at time of impact? _____

What speed was the other vehicle going at time of impact? _____

During and after the accident what happened to your vehicle?

(Circle all that apply)

***Kept going straight**

***Kept going straight hitting a car in front**

***Spun around**

***Hit a stationary object**

***Was hit by another vehicle**

***Spun around and hit a stationary object**

Did you lose consciousness during the accident? YES/NO

During the accident, what was the position of your:

Torso? _____ **Head?** _____ **Hands?** _____

During the accident, did you hit anything with your:

Head? YES/NO please describe _____
Face? YES/NO please describe _____
Shoulders? YES/NO please describe _____
Neck? YES/NO please describe _____
Chest? YES/NO please describe _____
Hips? YES/NO please describe _____
Knees? YES/NO please describe _____
Feet? YES/NO please describe _____

What kind of headrest was in your vehicle? (Please circle one)

- *movable fixed headrest
- *non movable fixed headrest
- *no headrest

Where was your head positioned on your headrest? _____

Were you wearing your seatbelt during the accident? YES/NO If yes, did you slide out of your seatbelt during the accident? YES/NO

What was the damage done to your vehicle? (Circle all that apply)

- *Windshield
- *Rear bumper
- *Mirror
- *Steering Wheel
- *Front bumper
- *Knee bolster
- *Dashboard
- *Trunk
- *Back right door
- *Seat frame
- *Front left door
- *Completely totaled
- *Side window
- *Front right door
- *Back left door
- *Rear window

Circle the items that dented inward:

- *Floorboards
- *Side door
- *Dashboard

Circle the doors that would not open due to the accident:

- *Front left
- *Front right
- *Rear left
- *Rear Right

Did you go to the hospital? YES/NO If no, please explain. _____

If yes, please answer the rest of the questions.

How did you get to the hospital? _____

What was the name of the hospital? _____

Were you hospitalized over night? _____

**Did you receive any of the following at the hospital?
(Circle all that apply)**

***Pain Medication *Muscle relaxers *Neck brace *Stitches**

Were any x-rays taken at the hospital? YES/NO If yes, of which area?
