Automobile Accident Questionnaire

Dr Jason Hart, DC

Patient Name: _____

Date of Accident: _____ **Time of day of accident:** _____

Where did the accident occur? (State) _____

Please describe the accident in your own words _____

Please answer all questions that apply to you.

Your vehicle type (make, model, year): _____

Your position in the vehicle: ❑ **Driver** ❑ **Front Passenger** ❑ **Left Rear** ❑ **Middle Rear** ❑ **Right Rear**

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

Speed of your vehicle: ❑ **Stopped** ❑ **Parked** ❑ **Moving at approx** ____ **mph** ❑ **Other:** _____

Collision Type: ❑ **Driver side impact** ❑ **Passenger side impact** ❑ **Front impact** ❑ **Head on**
❑ **Rear Impact** ❑ **Pedestrian incident**

Other vehicle type (make, model, year): _____

Speed of other vehicle: ❑ **Stopped** ❑ **Parked** ❑ **Moving at approx** ____ **mph** ❑ **Other:** _____

Were you surprised by the impact? ❑ **No** ❑ **Yes** If "no", how did you brace yourself? _____

Which restraints apply? ❑ **Seat belt** ❑ **Shoulder harness** ❑ **Lap belt** ❑ **No restraints**

Was the airbag deployed? ❑ **No** ❑ **Yes** ❑ **Car not equipped with air bag**

What position was your headrest? ❑ **High** ❑ **Middle** ❑ **Low**

What was the position of your head at the time of impact? ❑ **Straight ahead** ❑ **Left** ❑ **Right** ❑ **Behind** ❑ **Leaning**

As a result of the force of the collision, did your body strike anything in the vehicle? ❑ **No** ❑ **Yes**

If yes, please circle the part of the body that struck which object in the vehicle:

- ❑ **Steering Wheel:** head, chest, chin, left arm, right arm, torso, left leg, right leg, other:_____
- ❑ **Dashboard:** head, chest, chin, left arm, right arm, torso, left leg, right leg, other:_____
- ❑ **Windshield:** head, chest, chin, left arm, right arm, torso, left leg, right leg, other:_____
- ❑ **Armrest:** head, chest, chin, left arm, right arm, torso, left leg, right leg, other:_____
- ❑ **Headrest:** head, chest, chin, left arm, right arm, torso, left leg, right leg, other:_____
- ❑ **Rear view mirror:** head, chest, chin, left arm, right arm, torso, left leg, right leg, other:_____
- ❑ **Left door:** head, chest, chin, left arm, right arm, torso, left leg, right leg, other:_____
- ❑ **Right door:** head, chest, chin, left arm, right arm, torso, left leg, right leg, other:_____
- ❑ **Left window:** head, chest, chin, left arm, right arm, torso, left leg, right leg, other:_____
- ❑ **Right window:** head, chest, chin, left arm, right arm, torso, left leg, right leg, other:_____
- ❑ **Other:** head, chest, chin, left arm, right arm, torso, left leg, right leg, other:_____

Immediately following the accident, did you feel:

❑ **Dizzy** ❑ **Dazed** ❑ **Disoriented** ❑ **Weak** ❑ **Nervous** ❑ **Nauseated** ❑ **Other:** _____

Did you lose consciousness? ❑ **No** ❑ **Yes**

Did you feel pain immediately following the accident? ❑ **No** ❑ **Yes: Where?** _____

Were citations issued for the accident? ❑ **No** ❑ **Yes: To whom?** _____

Were you able to walk unaided? ❑ **No** ❑ **Yes**

Did you go to the hospital? ❑ **No** ❑ **Yes: When and How?** _____

Were you admitted to the hospital? ❑ **No** ❑ **Yes: How long?** _____ **Which hospital?** _____

What treatment did you receive? _____

Next day discomfort: ❑ **Increased** ❑ **Decreased** ❑ **Same**

Did your major complaints exist before the accident? ❑ **No** ❑ **Yes**