

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 _____
 Other _____

Vehicle size:

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

Your position in the vehicle:

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

Speed of your vehicle: stopped:

- Stopped Moving Moderately
 Parked Moving Fast
 Slowing Moving at apprx ____MPH
 Moving Slowly

Why Vehicle was slowed or

- Traffic Signal Parking
 Pedestrian Traffic
 Stop Sign Busy Intersection

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 _____
 Other _____

Vehicle size:

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

CONDITIONS AT THE TIME OF THE ACCIDENT:

Time of day: compromised by:

- Full daylight

 Dusk
 Night

Road Conditions:

- Dry
 Damp
 Wet
 Snow covered
 Ice covered
 Patchy Ice/Snow

Visibility:

- Excellent
 Good
 Fair
 Poor

Visibility

- Brightness
 Darkness
 Rain
 Snow
 Fog
 Traffic

THE FOLLOWING QUESTIONS CONCERN THE MOMENT OF IMPACT OF THE ACCIDENT:

Were you...

Restraints: (check all that apply)

- Totally unaware that the accident was impending
- Aware that the accident was impending
- Aware that the accident was impending and braced for it
- 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

Position of YOUR head at time of impact?

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

Was your head thrown...?

- Backward and then forward
- Forward then backward
- To the left To the right
- To the right To the right, then 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 passenger of
- Was totalled
- Not known

Citations:

- None issued
- Yourself
- Driver of vehicle patient was a
- 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 door
- Dashboard window
- Windshield window
- Armrest Console
- Headrest
- Right door
- Left window
- Right window
- Console
- Gear shift

Left Arm

- Steering wheel
- Dashboard
- Windshield
- Armrest
- Headrest
- Right
- Left
- Right
- Gear

shift

- Rear view mirror seat
- Left door
- Backseat

- Front seat
- Backseat

- Rear view mirror
- Front
- Left door

Right Arm

- Steering wheel door
- Dashboard window
- Windshield window
- Armrest
- Console
- Headrest shift
- Rear view mirror seat
- Left door
- Backseat

- 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
- Left
- Right
- Gear
- Front

Left Leg

- Steering wheel door
- Dashboard window
- Windshield window
- Armrest
- Console
- Headrest shift
- Rear view mirror seat
- Left door
- Backseat

- 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
- Left
- Right
- Gear
- Front

THE FOLLOWING QUESTIONS CONCERN THE TIME PERIOD IMMEDIATELY FOLLOWING THE ACCIDENT:

Did you lose consciousness? Immediately following the accident, did you feel...?

- Yes Dizzy Weak
- No Dazed Nervous
- Disoriented Nauseated

Were you able to walk unaided?

- Yes Drove home
- No Was driven home

Where did you go...?

- Drove to work
- 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...?
complaints exist before the accident?**

- increased decreased same 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 | | | | | | |

Did your major

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

At the hospital, what areas were x-rayed?

- | | | | | | | |
|---|----------|-------------------------------|--------------------------------|-------|-------------------------------|--------------------------------|
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| <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 |
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Patient's Signature: _____