AUTOMOBILE ACCIDENT QUESTIONNAIRE

Patient Name:

MO	DAY	YEAR	DR#	PATIENT NUMBER

Dear Patient:
This questionnaire will allow you to describe your automobile accident in detail. Please complete it carefully as the information provided will assist the doctor in evaluating and documenting your condition. THANK YOU.

Use a **No. 2 pencil** to mark your answers. When marking in an **Other** bubble please explain in the space allowed. Fill in bubbles **completely** as indicated here: ⬭. **Erase** changes cleanly. Do **not fold** form.

A. VEHICLE YOU WERE IN

1. Vehicle type?
Car · Pickup · Van · Truck · Station Wagon · Bus · Other

2. Vehicle size?
Subcompact · Full-Size · Compact · Mini · Mid-Size · Light · Other

3. What was your location in the vehicle?
Driver · Front Passenger · Rear Passenger
Passenger Location: Left · Middle · Right
Other

4. What was the vehicle you were in doing?
Mark only ONE bubble below to answer this question

a. Vehicle stopped for
Traffic Light · Intersection · Stop Sign · Traffic · Pedestrian · Parked · Other

b. Vehicle slowing down for
Traffic Light · Intersection · Stop Sign · Traffic · Pedestrian · Turning · Parking · Other

c. Vehicle moving
Slowly · Moderately · Fast · ____ MPH · Accelerating · Other

d. Vehicle doing other
Other

5. What damage did the vehicle you were in sustain?
Minimal · Moderate · Extensive · Totaled · Unsure · Other

B. IF OTHER VEHICLES INVOLVED IN ACCIDENT

1. First Vehicle To Strike Vehicle You Were In

a. Vehicle type?
Car · Pickup · Van · Truck · Station Wagon · Bus · Other

b. Vehicle size?
Subcompact · Full-Size · Compact · Mini · Mid-Size · Light · Other

c. How did this vehicle strike the vehicle you were in?
Head On · From Right · From Left · Rear Ended · Sideswiped On Right · Sideswiped On Left · Other

d. What damage did this vehicle sustain?
Minimal · Moderate · Extensive · Totaled · Unsure · Other

2. Second Vehicle To Strike Vehicle You Were In

a. Vehicle type?
Car · Pickup · Van · Truck · Station Wagon · Bus · Other

b. Vehicle size?
Subcompact · Full-Size · Compact · Mini · Mid-Size · Light · Other

c. How did this vehicle strike the vehicle you were in?
Head On · From Right · From Left · Rear Ended · Sideswiped On Right · Sideswiped On Left · Other

d. What damage did this vehicle sustain?
Minimal · Moderate · Extensive · Totaled · Unsure · Other

3. Describe Other Vehicles To Strike Vehicle You Were In
Vehicle Type: · How it struck: · Vehicle Size: · Damage:

4. Were traffic citations issued as a result of the accident?
No Citations issued · Driver Of Other Vehicle · Driver Of Vehicle You Were In · You · Unsure

C. CONDITIONS AT TIME OF ACCIDENT

1. What time of day did the accident occur?
Daylight · Dawn · Dusk · Night · Other

2. What was the condition of the road?
Dry · Damp · Wet · Snow Covered · Icy · Other

3. Visibility

a. What was the visibility at impact?
Good · Fair · Poor · Other

b. If visibility was poor, why?
Sun Light · Darkness · Rain · Snow · Fog · Traffic · Other

PLEASE MAKE NO MARKS IN THIS AREA

D. AT MOMENT OF IMPACT

1. Were you prepared for the accident?

- ◯ Accident A Complete Surprise
- ◯ Aware Of Impending Collision ◯ And Braced For Impact

2. Foot On Brake Pedal

a. Was your foot on brake pedal at impact? ◯ Yes ◯ No

b. Was it knocked off pedal by impact? ◯ Yes ◯ No

3. Use Of Restraints

a. Restraint Belts

1. Were you wearing a restraint belt? ◯ Yes ◯ No

2. What type of restraint belt were you wearing?

◯ Shoulder-Lap Belt ◯ Shoulder Belt ◯ Lap Belt

b. Headrests

1. Was vehicle equipped with headrests? ◯ Yes ◯ No

2. What position was the headrest in?

◯ Low ◯ Middle ◯ High ◯ Don't Know

c. Air Bags

1. Was vehicle equipped with air bags?

◯ Yes ◯ No ◯ Unsure

2. Did the air bags deploy? ◯ Yes ◯ No

4. Your Body

a. What was your body position at impact?

◯ Straight ◯ Slouched Forward **Rotated:** ◯ Right ◯ Left
◯ Don't Recall ◯ Other

b. What direction was your body thrown?

◯ Forward\Backward ◯ Backward\Forward ◯ Sideways
◯ Across Vehicle ◯ Outside Vehicle ◯ Under Vehicle
◯ Don't Recall ◯ Other

5. Your Head And Neck

a. What position were your head/neck in at impact?

◯ Straight ◯ Tilted Forward **Rotated:** ◯ Right ◯ Left
◯ Don't Recall ◯ Other

b. Through what motion were your head/neck pitched?

◯ Forward\Backward ◯ Backward\Forward ◯ Sideways
◯ Don't Recall ◯ Other

E. RESULT OF IMPACT

1. Which objects in the vehicle did the force of the collision cause your body to strike?

a. Head

◯ Steering Wheel ◯ Dashboard ◯ Windshield
◯ Right Side Door ◯ Left Side Door ◯ Armrest
◯ Right Window ◯ Left Window ◯ Headrest
◯ Ceiling ◯ Console ◯ Shift Lever
◯ Front Seat ◯ Rear View Mirror
◯ Other

b. Right Upper Extremity (Arm)

◯ Steering Wheel ◯ Dashboard ◯ Windshield
◯ Right Side Door ◯ Left Side Door ◯ Armrest
◯ Right Window ◯ Left Window ◯ Headrest
◯ Ceiling ◯ Console ◯ Shift Lever
◯ Front Seat ◯ Rear View Mirror
◯ Other

c. Left Upper Extremity (Arm)

◯ Steering Wheel ◯ Dashboard ◯ Windshield
◯ Right Side Door ◯ Left Side Door ◯ Armrest
◯ Right Window ◯ Left Window ◯ Headrest
◯ Ceiling ◯ Console ◯ Shift Lever
◯ Front Seat ◯ Rear View Mirror
◯ Other

d. Torso

◯ Steering Wheel ◯ Dashboard ◯ Windshield
◯ Right Side Door ◯ Left Side Door ◯ Armrest
◯ Right Window ◯ Left Window ◯ Headrest
◯ Ceiling ◯ Console ◯ Shift Lever
◯ Front Seat ◯ Rear View Mirror
◯ Other

e. Right Lower Extremity (Leg)

◯ Steering Wheel ◯ Dashboard ◯ Windshield
◯ Right Side Door ◯ Left Side Door ◯ Armrest
◯ Right Window ◯ Left Window ◯ Headrest
◯ Ceiling ◯ Console ◯ Shift Lever
◯ Front Seat ◯ Rear View Mirror
◯ Other

f. Left Lower Extremity (Leg)

◯ Steering Wheel ◯ Dashboard ◯ Windshield
◯ Right Side Door ◯ Left Side Door ◯ Armrest
◯ Right Window ◯ Left Window ◯ Headrest
◯ Ceiling ◯ Console ◯ Shift Lever
◯ Front Seat ◯ Rear View Mirror
◯ Other

2. Did your body strike any other objects?

◯ Description Of Other Objects Your Body Hit:

F. ADDITIONAL INFORMATION

◯ Additional Information About Your Automobile Accident:

Patient's Or Guardian Signature: **Date:**

