

# 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
- Other \_\_\_\_\_
- Other \_\_\_\_\_

- Pickup
- Truck
- Bus

**Vehicle size:**

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

**Your position in the vehicle:**

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

**Speed of your vehicle:**

- Stopped
- Parked
- Slowing
- Moving Slowly
- Moving Moderately
- Moving Fast
- Moving at apprx \_\_\_\_ 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
- Other \_\_\_\_\_
- Pickup
- Truck
- Bus

**Vehicle size:**

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

**Visibility compromised by:**

- Brightness
- Darkness
- Rain
- Snow
- Traffic

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

**Were you...**

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

**Restraints: (check all that**

- 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
- Rotated to the right

**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

**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
- Was totalled
- Not known

**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

*THE FOLLOWING QUESTIONS CONCERN THE TIME 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       | 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 |                               |                                |       |                               |                                |

**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 |
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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       | Shoulder                        | <input type="checkbox"/> Left | <input type="checkbox"/> Right | 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?**

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

Patient's Signature: \_\_\_\_\_