PERSONAL INJURY/AUTO ACCIDENT QUESTIONNAIRE

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(Please fill out all information completely, indicate N/A if not applicable)

Name _____ Today's Date ____/_____/_____ Date of Accident ____/_____/_____

Please describe, to the best of your ability, what happened during this accident _____

_____

_____

_____

History of Occurrence

☐ Pedestrian ☐ Driver ☐ Passenger- Middle Front ☐ Passenger- Right Front
☐ Passenger- Left Rear ☐ Passenger- Center Rear ☐ Passenger -Right Rear

Patient Vehicle Type
☐ Compact ☐ Mid-size ☐ Full-Size ☐ SUV ☐ Pick-up ☐ Motorcycle ☐ Other _____

Second Vehicle Type
☐ Compact ☐ Mid-size ☐ Full-Size ☐ SUV ☐ Pick-up ☐ Motorcycle ☐ Other _____

Third Vehicle Type
☐ Compact ☐ Mid-size ☐ Full-Size ☐ SUV ☐ Pick-up ☐ Motorcycle ☐ Other _____

Road Conditions
☐ Dry ☐ Icy ☐ Wet ☐ Clear ☐ Foggy ☐ Dark ☐ Other _____

Road Type
☐ Concrete ☐ Asphalt ☐ Gravel ☐ Dirt ☐ Other _____

Were you aware the accident was going to occur? ☐ Yes ☐ No.
Were you wearing a seatbelt? ☐ Yes ☐ No
If yes, was it a: ☐ lap seatbelt ☐ shoulder-lap seatbelt
Did your airbag deploy? ☐ Yes ☐ No.
Does your car have a head rest? ☐ Yes ☐ No.
What position was the head rest in? ☐ Up ☐ Middle ☐ Down

Head Position: ☐ Looking Straight Ahead ☐ Left Level ☐ Left Up ☐ Left Down
☐ Right Level ☐ Right Up ☐ Right Down ☐ Looking Up ☐ Looking Down

Was your car braking? ☐ Yes ☐ No. Was your car moving? ☐ Yes ☐ No
If yes, how fast? (mph) ☐ <5 ☐ 6-10 ☐ 11-15 ☐ 16-20 ☐ 21-30 ☐ 31-40 ☐ 41-50 ☐ 51-60 ☐ 61-70 ☐ >70

Was the second vehicle braking? ☐ Yes ☐ No. Was the second vehicle moving? ☐ Yes ☐ No
If yes, how fast? (mph) ☐ <5 ☐ 6-10 ☐ 11-15 ☐ 16-20 ☐ 21-30 ☐ 31-40 ☐ 41-50 ☐ 51-60 ☐ 61-70 ☐ >70

Was the third vehicle braking? ☐ Yes ☐ No. Was the third vehicle moving? ☐ Yes ☐ No
If yes, how fast? (mph) ☐ <5 ☐ 6-10 ☐ 11-15 ☐ 16-20 ☐ 21-30 ☐ 31-40 ☐ 41-50 ☐ 51-60 ☐ 61-70 ☐ >70

Collision Details

First Impact: ☐ Hit by another vehicle ☐ Hit another vehicle ☐ Hit by an object ☐ Hit an object
(on the) ☐ Front ☐ Front-Right ☐ Front-Left ☐ Left ☐ Right ☐ Right-Rear ☐ Left-Rear ☐ Rear ☐ Top

Second Impact: ☐ Hit by another vehicle ☐ Hit another vehicle ☐ Hit by an object ☐ Hit an object
(on the) ☐ Front ☐ Front-Right ☐ Front-Left ☐ Left ☐ Right ☐ Right-Rear ☐ Left-Rear ☐ Rear ☐ Top

Collision Results

Body was thrown: □ Backward □ Forward □ Left □ Right □ Can't Remember

Head Hit:	□ Airbag	□ Another person's body	□ Back of front seat	□ Dashboard
	□ Front windshield	□ Rear-view mirror	□ Side window/door	□ Steering wheel
	□ Windshield			
Chest Hit:	□ Another person's body	□ Back of front seat	□ Dashboard	□ Side window/door
	□ Steering wheel			
Shoulders Hit:	□ Another person's body	□ Back of front seat	□ Shoulder harness	□ Side window/door
Knees Hit:	□ Another person's body	□ Back of front seat	□ Center console	□ Dashboard
	□ Door panel	□ Steering wheel		
Hips Hit:	□ Another person's body	□ Back of front seat	□ Center console	□ Dashboard
	□ Door panel	□ Steering wheel		

Vehicle Damage

First Vehicle: □ Totaled □ Significant damage □ Light damage □ No damage
Second Vehicle: □ Totaled □ Significant damage □ Light damage □ No damage
Third Vehicle: □ Totaled □ Significant damage □ Light damage □ No damage

Were you hospitalized? □ Yes □ No If yes, please answer the questions in the paragraph below.

When were you hospitalized? Date _____ □ Immediately □ Later the same day □ The next day.
How were you transported to the hospital? □ Ambulance □ Air lifted □ Private transportation
What did the hospital recommend? □ No instructions □ See this clinic □ See DC □ See own Doctor
□ See Neurologist □ See Orthopedist □ Over the counter medication □ Prescription medication
□ Other _____
Did you have any x-rays taken? □ Yes □ No If yes, what areas? _____

What are your current symptoms? □ Pain □ Numbness □ Stiffness □ Weakness □ Other_____
Did you have these symptoms prior to the injury? □ No □ Yes

Are you currently suffering from any of the following?

□ Restlessness	□ Irritability
□ Difficulty sleeping	□ Difficulty with memory
□ Sleeplessness	□ Forgetfulness
□ Reduced tolerance to heat	□ Reduced tolerance to alcohol

Did you lose consciousness (black out) upon impact? □ No □ Yes If yes, how long?_____

What bleeding cuts did you sustain during the accident? _____

What bruises did you sustain during the accident? _____

Any other comments?_____

_____

_____

Patient Signature_____ Date_____

CA Signature _____ Date _____