

Accident Questionnaire:

Patient Name: _____ Today's Date: _____

Date of Accident: _____

Location of Accident: _____

Questions About Accident Circumstance:

Year and make of the vehicle you were riding in: _____

Number of other vehicles (other than above) involved: _____

Year and make of other vehicles: #1 _____ #2 _____

Monetary Damage to your vehicle: \$ _____

Speed of vehicles at impact: Yours _____ #1 _____ #2 _____

Were you the _____ Driver or _____ Passenger

If you were the passenger where were you seated? _____

Were you wearing a seatbelt at the time? _____ YES _____ NO

Was your vehicle moving or stopped? _____

Did another vehicle strike your vehicle? _____ YES _____ NO

Did your vehicle strike another vehicle? _____ YES _____ NO

Where was your vehicle hit? _____

Describe the Impact: _____

Were Airbags deployed in your vehicle? _____ YES _____ NO

What were the road conditions? _____ Wet _____ Icy _____ SnowPacked _____ Dry

How far did your vehicle move after impact? _____ Car Lengths _____ Feet

Questions About Your circumstances at impact:

Did you see the impact approaching? _____ YES _____ NO

Did you brace yourself for impact? _____ YES _____ NO

Were you looking: _____ forward _____ upward _____ downward _____ to left _____ to right

Were you looking in the mirror? _____ YES _____ NO

What was your body position at time of impact? _____ neutral _____ forwarded

_____ rotated to the left/right

Which direction was your head turned? _____ neutral _____ rotated to the left/right

Did any part of your body strike another object? _____ dashboard _____ window _____ other

Were you able to get out of the vehicle and walk on your own? _____ YES _____ NO

Was your car drivable from the scene of the accident? _____ YES _____ NO

Did you go to the hospital? _____ YES _____ NO
If you went to the hospital did you stay over night?
Were x-rays taken? _____ YES _____ NO Was MRI taken? _____ YES _____ NO
Were you instructed on any of the following? _____ Ice _____ Heat _____ Other
Was medication prescribed? _____ YES _____ NO What kind? _____

Did you experience any of the following at the time of impact?
_____ cuts _____ bruises _____ abrasions _____ dislocations _____ bumps
where: _____
_____ immediate dizziness
_____ nausea _____ vision problems _____ altered consciousness
_____ head pain _____ loss of consciousness
_____ body pain : where _____

Describe in your own words how you felt after the accident and the progression of symptoms:
Immediately after accident: _____

2-3 Hours after accident: _____

That Night: _____

Next Day: _____

2-5 days later: _____

other: _____

Have your symptoms kept you from doing anything? _____ YES _____ NO
If so, what? _____ Work _____ Sleep _____ Exercise _____ Sit _____ Stand _____
_____ Sex _____ Other normal daily activities? If so what? _____

Who was at fault in this accident? _____
Did the police write any tickets? _____ YES _____ NO Who was ticketed? _____

Signature: _____