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Auto Accident Questionnaire

Name: _____ Today's Date: _____

1. Date of Accident _____ Time of Accident _____ AM / PM
2. Name of Driver of Car_____ Where were you seated

   _____
3. Type of Accident: ( ) head-on collision ( ) broad-side collision ( ) rear-end collision
   ( ) front impact, rear-end of car *in front* ( ) non-collision (describe): _____

   _____
4. Describe in your own words what happened to you upon impact: _____

   _____
5. Did you brace for impact? YES / NO Was the car breaking? YES / NO
6. Were shoulder harnesses worn? YES / NO Were seat belts worn? YES / NO
7. Does your car have headrests? YES / NO
   - If yes, what was the position of the headrests compared to your head before the accident?

   ( ) top of headrest even with <u>top</u> of head ( ) top of headrest even with <u>bottom</u> of head
   ( ) top of headrest even with <u>middle of neck</u>
8. Was your car moving at the time of the accident? YES / NO
   - If yes, how fast would you estimate that you were going? _____mph
9. How fast was the other car traveling? _____mph, other:
10. Head/body position at the time of impact: ( ) head turned left / right ( ) head looking back
    ( ) body straight in sitting position ( ) body rotated left / right ( ) head straight forward
11. At the time of the accident, recall what parts of your head or body hit what parts on the inside of your car: _____

    _____

    _____
12. As a result of the accident you were: ( ) rendered unconscious ( ) dazed, circumstances vague
    ( ) other (describe): _____

    _____
13. Could you move all parts of your body after the accident? YES / NO If no, what parts and why?

    _____

    _____

    _____
14. Were you able to get out of the car and walk unaided? YES / NO If no, why not? _____

    _____

    _____
15. What bleeding cuts did you get from this accident? _____

    _____
16. What bruises did you get from this accident? _____

    _____

17. Please describe how you felt immediately after the accident. Please **BE SPECIFIC**. _____
_____
_____
18. Please describe how you felt later that ( ) day ( ) night _____
_____
19. Please describe how you felt the next ( ) day ( ) days _____
_____
20. Check symptoms apparent *since* the accident:

( ) headache	( ) loss of smell	( ) numbness in toes	( ) cold hands
( ) neck pain/stiffness	( ) loss of taste	( ) numbness in fingers	( ) cold feet
( ) mid-back pain	( ) loss of memory	( ) loss of balance	( ) diarrhea
( ) low back pain	( ) fatigue	( ) shortness of breath	( ) chest pain
( ) eyes sensitive to light	( ) tension	( ) dizziness	( ) fainting
( ) constipation	( ) pain behind eyes	( ) nervousness	( ) irritability
( ) depression	( ) cold sweats	( ) ringing/buzzing ears	( ) anxious
( ) sleeping problems	( ) other _____		

21. Occupation _____ Employer _____
_____ _____
22. Have you missed time for work? **YES** / **NO** If yes, please indicate:
Full-time off work _____ to _____ : _____ to _____
Part-time off work _____ to _____ : _____ to _____
( ) unable to work since accident
23. Did you see medical help immediately / soon after the accident? YES / NO
24. If yes, how did you get there? ( ) someone drove me ( ) drove my own car ( ) ambulance
( ) police ( ) other_____
25. Doctor/Hospital/Clinic seen: _____
_____ Date: _____
26. Were you examined? YES / NO
27. Were x-rays taken? YES / NO If yes, what body part(s) _____
28. What treatment was given to you? ( ) bed rest ( ) brace ( ) physiotherapy ( ) drugs
( ) adjustments ( ) other _____
29. What benefits did you receive from the treatment? _____
_____
30. Date of last treatment: _____
31. Have you sought or had any treatment other than doctor listed above? YES / NO If yes, what
Doctor/Hospital/Clinic: _____
32. Did you have any physical complaints just before the accident? YES / NO If yes, please
describe in detail: _____
_____
_____