

## Automobile Accident Questionnaire

### Accident Information

Name: \_\_\_\_\_ Date: \_\_\_\_\_

1. Date of Accident: \_\_\_\_\_ Time: \_\_\_\_\_ a.m./p.m.

2. Driver of car: \_\_\_\_\_ Where you were seated: \_\_\_\_\_

3. Owner of car: \_\_\_\_\_ Year and Model of car: \_\_\_\_\_

4. Visibility at time of accident: poor/fair/good/other: \_\_\_\_\_

5. Road conditions at time of accident: icy/rainy/wet/clear/dark/other: \_\_\_\_\_

6. Where was your car struck? right/left/rear/front/side/other: \_\_\_\_\_

7. Type of accident:  head-on collision  broad-side collision  rear-end collision

front impact, rear-ended car in front  non-collision: \_\_\_\_\_

8. What part of the car was damaged? \_\_\_\_\_

9. Describe what happened to you upon impact? \_\_\_\_\_

10. Did you see the accident was about to happen?  Yes  No

11. Did you brace for impact?  Yes  No

12. Were you wearing a seatbelt?  Yes  No

13. Were you wearing a shoulder harness?  Yes  No

14. Does the car have headrests?  Yes  No

15. If yes, what was the position of your headrest?  top of headrest even with bottom of head

top of headrest even with top of head  top of headrest even with middle of head

16. Was your car braking?  Yes  No Was the other car braking?  Yes  No

17. Was your car moving at the time of the accident?  Yes  No

If yes, how fast would you estimate you were going? \_\_\_\_\_

18. How fast would you estimate the other car was traveling? \_\_\_\_\_

19. What was the position of your head and body at the time of impact?

head turned left/right  body straight in sitting position  head looking back

body rotated left/right  head straight forward  other: \_\_\_\_\_

20. At the time of the accident, recall what parts of your head or body hit what parts of the vehicle:

\_\_\_\_\_  
\_\_\_\_\_

21. As a result of the accident were you:  rendered unconscious  dazed  other: \_\_\_\_\_

22. Could you move all parts of your body?  yes  no

If no, why not? \_\_\_\_\_

23. Were you able to get out of the car and walk unaided?  yes  no

If no, why not? \_\_\_\_\_

24. Did you have any cuts or bruises from this accident?  yes  no

If so, where? \_\_\_\_\_

25. Describe how you felt immediately after the accident? \_\_\_\_\_

\_\_\_\_\_

How did you feel later that  day  night? \_\_\_\_\_

How did you feel the next day(s)? \_\_\_\_\_

26. Check symptoms apparent since the accident:

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

27. Have you missed time from work?  yes  no      Work hours are:  full-time  part-time

If you have missed time from work, how much time have you missed? \_\_\_\_\_

28. Did the accident occur during your work hours?  yes  no

29. Did you seek medical help immediately/soon after the accident?  yes  no

If yes, how did you get there? \_\_\_\_\_

30. Doctor/hospital/clinic seen: \_\_\_\_\_ Date: \_\_\_\_\_

31. What was done? \_\_\_\_\_

Were x-rays taken?  yes  no If yes, of what body part? \_\_\_\_\_

32. What treatments/prescriptions were given?  bed rest  brace  adjustments  medications

33. What benefit(s) did you receive from treatment(s)? \_\_\_\_\_

34. Date of last treatment: \_\_\_\_\_

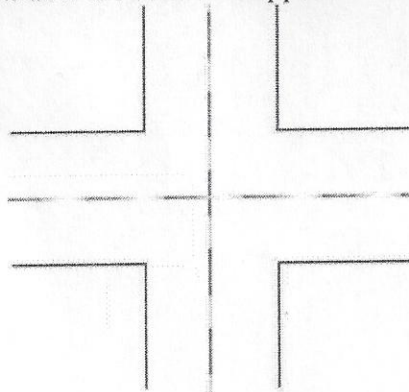
35. Are any of your activities of daily living any different now compared to before the accident?  
 yes  no

List anything you are unable to do: \_\_\_\_\_

List anything that is painful to do: \_\_\_\_\_

List anything that is difficult to do: \_\_\_\_\_

36. Indicate on the diagram below how the accident happened:



Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

37. Do you have an attorney handling this case?  yes  no

If yes, who? (name/address) \_\_\_\_\_

\_\_\_\_\_

**Insurance Information**

Patient's personal insurance: \_\_\_\_\_

Insured's name (if other than patient) \_\_\_\_\_

Policy #: \_\_\_\_\_

Insurance Company Name: \_\_\_\_\_

Phone#: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State/Zip: \_\_\_\_\_

Claim #: \_\_\_\_\_ Adjuster's name/phone: \_\_\_\_\_

\_\_\_\_\_

Other party's insurance: \_\_\_\_\_

Insured's name (if other than patient) \_\_\_\_\_ Policy #: \_\_\_\_\_

Insurance Company Name: \_\_\_\_\_ Phone#: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State/Zip: \_\_\_\_\_

Claim #: \_\_\_\_\_ Adjuster's name/phone: \_\_\_\_\_

Other insurance: \_\_\_\_\_

Insured's name (if other than patient) Policy #: \_\_\_\_\_

Insurance Company Name: \_\_\_\_\_

Phone#: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State/Zip: \_\_\_\_\_