

Absolute Chiropractic & Wellness

AUTOMOBILE ACCIDENT QUESTIONNAIRE

Today's Date: _____

Patient's Name: _____
(Last name) (First name) (M.I.)

Date of Accident: _____

Please describe vehicle you were in during the accident.

Vehicle Type:

- Car
- Van
- SUV
- Other _____
- Pickup
- Truck
- Bus

Vehicle size:

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

Your position in the vehicle:

- Driver
- Passenger
- Other _____

If passenger, where were you seated:

- Front passenger
- Rear passenger
 - Middle
 - Left
 - Right
- Third Seat (rear)

Speed of your vehicle:

- Stopped
- Parked
- Slowing
- Moving slowly
- Moving moderately
- Moving fast
- Moving at approx __MPH

Why was the vehicle slowed or stopped:

- Traffic signal
- Pedestrian
- Stop sign
- Parking
- Traffic
- Busy intersection

Collision Type:

- Driver side impact
- Front impact
- Passenger side impact
- Head on collision
- Pedestrian incident
- Rear impact

Please describe the other vehicle involved in the accident.

Vehicle Type:

- Car
- Van
- SUV
- Other _____
- Pickup
- Truck
- Bus

Vehicle size:

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

What were the conditions at the time of the accident?

Time of day:

- Full daylight
- Dusk
- Night

Road Conditions:

- Dry
- Damp
- Wet
- Snow-covered
- Ice-covered
- Patchy ice/snow

Visibility:

- Excellent
- Good
- Fair
- Poor

Visibility compromised by:

- Brightness
- Darkness
- Rain
- Snow
- Fog
- Traffic

Please describe the moment of impact during the accident.

Were you:

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

Restraints:(check all that apply)

- Seat belt
- Shoulder harness
- No restraints

Was your foot on the brake pedal?

- Yes
- No

Knocked off by impact

Was the airbag 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 then forward
- Forward than backward
- To the left
- To the right
- To the left then right
- To the right then 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 and then right
- To the right
- To the right and then 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 totaled
- Not known

Citations:

- None issued
- Yourself
- Driver of vehicle patient was passenger of
- Other driver
- Not sure

As a result of the force of the collision, against what part of 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
- Back seat

Left Arm

- Steering wheel
- Dashboard
- Windshield
- Armrest
- Headrest
- Rear view mirror
- Left door
- Right door
- Left window
- Right window
- Console
- Gear shift
- Front seat
- Back seat

Right Arm

- Steering wheel
- Dashboard
- Windshield
- Armrest
- Headrest
- Rear view mirror
- Left door
- Right door
- Left window
- Right window
- Console
- Gear shift
- Front seat
- Back seat

Torso

- Steering wheel
- Dashboard
- Windshield
- Armrest
- Headrest
- Rear view mirror
- Left door
- Right door
- Left window
- Right window
- Console
- Gear shift
- Front seat
- Back seat

Left leg

- Steering wheel
- Dashboard
- Windshield
- Armrest
- Headrest
- Rear view mirror
- Left door
- Right door
- Left window
- Right window
- Console
- Gear shift
- Front seat
- Back seat

Right leg

- Steering wheel
- Dashboard
- Windshield
- Armrest
- Headrest
- Rear view mirror
- Left door
- Right door
- Left window
- Right window
- Console
- Gear shift
- Front seat
- Back seat

Explain your condition and the events that directly followed the accident.

Did you lose consciousness?

- Yes
- No

Immediately following the accident, did you feel?

- Dizzy
- Dazed
- Disoriented
- Weak
- Nervous
- Nauseated

Were you treated at the scene?

- Yes
- No

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

Hospital Name: _____

Date of hospital visit: _____

Were you admitted: Yes/No

Next day discomfort?

- Increased
- Decreased
- Remained the 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 | | | | | | |

Did you feel any numbness or tingling?

- Yes If so, describe where: _____
- No

In what areas did you experience lacerations? (cuts)

- | | | | | | | |
|-------------------------------------|----------|-------------------------------|--------------------------------|-------|-------------------------------|--------------------------------|
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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 | | | | | | |

As result of the accident, did you have to take time off from work or school?

- Yes If so, give dates missed: _____
- No

Do you have an attorney: Yes/No

Attorneys information: Name _____
Address: _____

Phone: _____

Insurance Information: : Name _____
Address: _____

Phone: _____
Contact person: _____
Claim #: _____

Patients Signature: _____
Today's Date: _____