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
❑ Remained the same
❑ Decreased

Did your major complaints exist before the accident?

❑ Yes
❑ No

In what areas did you immediately feel pain?

❑ Head	Shoulder	❑ Left	❑ Right	Hip	❑ Left	❑ Right
❑ Neck	Arm	❑ Left	❑ Right	Thigh	❑ Left	❑ Right
❑ Upper back	Elbow	❑ Left	❑ Right	Knee	❑ Left	❑ Right
❑ Mid back	Wrist	❑ Left	❑ Right	Calf	❑ Left	❑ Right
❑ Ribs	Hand	❑ Left	❑ Right	Ankle	❑ Left	❑ Right
❑ Chest	Fingers	❑ Left	❑ Right	Foot	❑ Left	❑ Right
❑ Abdomen	Buttock	❑ Left	❑ Right	Toes	❑ Left	❑ Right
❑ Low Back						
❑ Pelvis						

Did you feel any numbness or tingling?

❑ Yes If so, describe where:_____
❑ No

In what areas did you experience lacerations? (cuts)

❑ Head	Shoulder	❑ Left	❑ Right	Hip	❑ Left	❑ Right
❑ Neck	Arm	❑ Left	❑ Right	Thigh	❑ Left	❑ Right
❑ Upper back	Elbow	❑ Left	❑ Right	Knee	❑ Left	❑ Right
❑ Mid back	Wrist	❑ Left	❑ Right	Calf	❑ Left	❑ Right
❑ Ribs	Hand	❑ Left	❑ Right	Ankle	❑ Left	❑ Right
❑ Chest	Fingers	❑ Left	❑ Right	Foot	❑ Left	❑ Right
❑ Abdomen	Buttock	❑ Left	❑ Right	Toes	❑ Left	❑ Right
❑ Low back						
❑ Pelvis						

At the hospital, what areas were x-rayed?

❑ Head	Shoulder	❑ Left	❑ Right	Hip	❑ Left	❑ Right
❑ Neck	Arm	❑ Left	❑ Right	Thigh	❑ Left	❑ Right
❑ Upper back	Elbow	❑ Left	❑ Right	Knee	❑ Left	❑ Right
❑ Mid back	Wrist	❑ Left	❑ Right	Calf	❑ Left	❑ Right
❑ Ribs	Hand	❑ Left	❑ Right	Ankle	❑ Left	❑ Right
❑ Chest	Fingers	❑ Left	❑ Right	Foot	❑ Left	❑ Right
❑ Abdomen	Buttock	❑ Left	❑ Right	Toes	❑ Left	❑ Right
❑ Low back						
❑ Pelvis						

Where did you experience pain on the day following the accident?

❑ Head	Shoulder	❑ Left	❑ Right	Hip	❑ Left	❑ Right
❑ Neck	Arm	❑ Left	❑ Right	Thigh	❑ Left	❑ Right
❑ Upper back	Elbow	❑ Left	❑ Right	Knee	❑ Left	❑ Right
❑ Mid back	Wrist	❑ Left	❑ Right	Calf	❑ Left	❑ Right
❑ Ribs	Hand	❑ Left	❑ Right	Ankle	❑ Left	❑ Right
❑ Chest	Fingers	❑ Left	❑ Right	Foot	❑ Left	❑ Right
❑ Abdomen	Buttock	❑ Left	❑ Right	Toes	❑ Left	❑ Right
❑ Low back						
❑ 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:_____