



## AUTO ACCIDENT / INJURY QUESTIONNAIRE

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

Date of Accident \_\_\_\_/\_\_\_\_/\_\_\_\_ Time of Accident \_\_\_\_\_ am pm

### **About the Accident:**

Were you the:  Driver  Front Passenger  Rear Passenger

Make and model of the vehicle you were occupying? \_\_\_\_\_

Total # of people in the vehicle: \_\_\_\_\_

Were the police notified?  yes  no

Was a police report filed?  yes  no

Were citations issued at the scene?  yes  no

Were there any witnesses?  yes  no

Were you wearing a seat belt?  yes  no If yes,  lap/shoulder belt  lap belt only

Was the vehicle equipped with airbags?  yes  no If yes, did they deploy?  yes  no

Did any part of your body strike anything inside the vehicle?  yes  no If yes, describe \_\_\_\_\_

What did your vehicle impact?  another vehicle  other \_\_\_\_\_

Name of the street/location on which you were traveling? \_\_\_\_\_

Direction you were traveling?  N  S  E  W

Approximate speed of your vehicle? \_\_\_\_\_ mph

If you were moving, were you:  at a steady speed  slowing down  braking for the accident

Amount of traffic at the time of the accident?  light  moderate  heavy

Weather conditions at time of accident?  clear / dry  wet / rainy  overcast / dry

During the impact, which direction were your facing?  Forward  Right  Left

What part of your vehicle was impacted?  Right side  Left side  Front  Rear  Other

Were you aware or surprised by the impact?  Aware  Surprised

Make and model of other vehicle(s) involved? \_\_\_\_\_

Direction other vehicle(s) were traveling?  N  S  E  W

Approximate speed of other vehicle(s)? \_\_\_\_\_ mph

Briefly describe in your own words what happened: \_\_\_\_\_

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**After the accident**

Did you lose consciousness after the impact?  yes  no If so, for how long? \_\_\_\_\_

Describe briefly how you felt after the accident: \_\_\_\_\_

Did you receive emergency care at the scene?  yes  no If yes, describe: \_\_\_\_\_

Where did you go immediately after the accident?  home  work  emergency room  other \_\_\_\_\_

Have you gone to the hospital or seen any other doctor?  yes  no

If yes, list name of hospitals and/or doctors along with dates: \_\_\_\_\_

Describe any treatment you have received: \_\_\_\_\_

Were X-rays taken?  yes  no

Was medication prescribed?  yes  no

Have you been able to work since this injury?  yes  no

Are your work activities restricted since this injury?  yes  no

Check the symptoms you have experienced since the accident:

- |   |   |  |  |
|---|---|--|--|
| <input type="checkbox"/> Headaches      | <input type="checkbox"/> Shoulder pain                  | <input type="checkbox"/> Fatigue             | <input type="checkbox"/> Blurred vision      |
| <input type="checkbox"/> Neck pain      | <input type="checkbox"/> Tension across shoulders       | <input type="checkbox"/> Dizziness           | <input type="checkbox"/> Ringing in ears     |
| <input type="checkbox"/> Neck stiffness | <input type="checkbox"/> Arm /hand pain                 | <input type="checkbox"/> Memory loss         | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Back pain      | <input type="checkbox"/> Numbness in arms/hands/fingers | <input type="checkbox"/> Difficulty sleeping | <input type="checkbox"/> Chest pain          |
| <input type="checkbox"/> Back stiffness | <input type="checkbox"/> Leg/foot pain                  | <input type="checkbox"/> Irritability        | <input type="checkbox"/> Stomach upset       |
| <input type="checkbox"/> Low back pain  | <input type="checkbox"/> Numbness in legs/feet/toes     | <input type="checkbox"/> Nausea              | <input type="checkbox"/> Other _____         |

Is your condition getting worse?  yes  no

Is your condition aggravated by any of the following?

- |                                   |   |                                   |                                      |
|-----------------------------------|---|-----------------------------------|--------------------------------------|
| <input type="checkbox"/> Sitting  | <input type="checkbox"/> Lying on back    | <input type="checkbox"/> Working  | <input type="checkbox"/> Pulling     |
| <input type="checkbox"/> Standing | <input type="checkbox"/> Lying on side    | <input type="checkbox"/> Lifting  | <input type="checkbox"/> Reaching    |
| <input type="checkbox"/> Walking  | <input type="checkbox"/> Lying on stomach | <input type="checkbox"/> Bending  | <input type="checkbox"/> Stretching  |
| <input type="checkbox"/> Running  | <input type="checkbox"/> Resting          | <input type="checkbox"/> Kneeling | <input type="checkbox"/> Other _____ |

Please provide any additional information that we should know: \_\_\_\_\_

\_\_\_\_\_  
Patient Name (printed)

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date