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AUTO ACCIDENT QUESTIONNAIRE

Patient's Name: ______________________
Today's Date: _______________________
Date of injury: _______________________

INJURY HISTORY

Was the accident on the job? ____Yes ____ No
You were: ____ Driver ____ Front seat passenger ____ Rear seat passenger
____ Motorcycle operator ____ Motorcycle passenger ____ Other
Vehicle driven by: ____
Your vehicle (year, make, & model): _____________________________
Your estimated speed at moment of accident:______________________
____ Stopped ____ Slowing ____ Accelerating
Time of Day: ___________________________
Road Conditions: ____ Dry ____ Damp ____ Wet ____ Snow ____ Ice
Head Restraints: ____ None ____ Integral Type
___ Adjustable Type: ___ Up ___ Down ___ Don't Know
If adjustable, was the position altered by the accident? ___ Yes ___ No
Was the seat broken? ____ Yes ____ No
Lap belt: ____ Wearing ____ Not wearing ____ Don't know
Shoulder belt: ____ None ____ Wearing ____ Not wearing ____ Don't know
Did air bag deploy? ____ Yes ____ No
Body position: ____ Good ____ Forward lean
Other ____
Head position: ____ Forward ____ Head turned left ____ Head turned right
____ Head up ____ Head down ____ Other ____________________________
Hands: ____ One on wheel ____ Two on wheel ____ N/A
Brakes applied? ____ Yes ____ No
Aware of impending crash? ____ Yes ____ No
Accident Description: ____
____
____

Did you strike any parts of the vehicle? ____ Yes ____ No
If yes, describe: ____
Did vehicle strike any objects after crash? ____ Yes ____ No
If yes, describe: ____
Did you lose consciousness? ____ Yes ____ No
If yes, for how long? ____

AFTER THE ACCIDENT

Symptoms: ____ Headache ____ Dizziness ____ Nausea ____ Neck pain
____ Confusion/Disorientation ____ Paresthesia ____ Low Back pain
If yes, or other symptoms, where? ____
____
Any pain in your extremities (arms, legs, etc.) ____ Yes ____ No
If yes, where? ____
When did your symptoms first appear? ____ Immediately ____ Hours ____ Days
Where did you go after the accident? ____ Home ____ Work ____ Hospital
Mode of transportation: ____

TREATMENT HISTORY

Did you go to the emergency room? ____ Yes ____ No
If yes, state when and what hospital: ____
____

X-Rays: ____ Yes ____ No
Body parts imaged ____
____ Cervical Collar ____ Ice
Medications: ____
____
Other treatment: ____
Follow-up instructions: ____ None ____ Yes, explain______________________
____

1. Dr.: ____
Specialty: ______________________________________ Date first seen: ______________
Treatment type: ___________________________ Treatment frequency: ________________
Treatment duration: _________________________ Currently treating? ___ Yes ___ No
Did treatment help? ____ Yes ____ No

2. Dr.: ____
Specialty: ______________________________________ Date first seen: ______________
Treatment type: ___________________________ Treatment frequency: ________________
Treatment duration: _________________________ Currently treating? ___ Yes ___ No
Did treatment help? ____ Yes ____ No

Notes: ____
____