

Patient Questionnaire – Auto-Accident

Patient Name: _____

Today's Date: ___/___/___

Basic Information about the Accident:

Date Accident Occurred or Started: ___/___/___

Time of Day when Accident Occurred or Started: ___:___ AM / PM

Describe how the Accident took place: _____

Describe the condition or symptoms caused by the Accident: _____

Auto-Accident Specific Information:

Were you the: Driver Passenger Pedestrian

Automobile you were in: Year _____ Make _____ Model _____

Damage to your car: Front Rear Pedestrian Driver Side Passenger Side Bumper Fender

Damage Amount Estimate: \$ _____ : Minor Major Totaled

Other Automobile: Year _____ Make _____ Model _____

Damage to other car: Front Rear Pedestrian Driver Side Passenger Side Bumper Fender
 Minor Major Totaled

Where did the accident happen? Street Names: _____ City/State _____

Was it? Controlled Intersection Uncontrolled Not Intersection

Was there a traffic light? None Green Red Turn Arrow Stop Sign

Were you: Slowly Moving Moving Stopped

Weather Conditions: Sunny Rainy Cloudy

Street Surface: Dry Wet Slick Icy Pavement Other _____

Type of Impact: Rear end Front Side Impact Roll Over

Brakes on Impact: Locked Tight Loosely Applied Foot not on brake

How far did your car move? Did not move Moved 1-5 ft Moved 6-10 ft Moved over 10 ft

Where were you seated in the vehicle: _____ Wearing Seat belt? Yes No

Shoulder harness: Yes No Headrest: Yes No Headrest Position: Up Down

Is the car equipped with airbags? Yes No Did they deploy? Yes No

Did you see the impact coming? Yes No Did you brace yourself for impact? Yes No

On impact, your head was looking: Ahead Behind Up Down To the Right To the Left

On impact were you: Thrown forward Thrown backwards Thrown sideways Other _____

Did your body hit anything inside the car? Yes No Body Part: _____

What did it hit? _____

Head trauma? Yes No Loss of Consciousness? Yes No For how long? _____

Do you remember the accident happening? Yes No

Hospital? Yes No Name of hospital: _____ How long there? _____

Taken by ambulance? Yes No

X-rays taken? Yes No X-ray areas: Neck Mid-back Low-back Other X-rays _____

Medication Given? Yes No RX: _____