

## AUTOMOBILE COLLISION QUESTIONNAIRE

### General Information:

Name \_\_\_\_\_ Phone Number \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

### Nature of Collision:

1. Date of Collision? \_\_\_\_\_ 20\_\_\_\_ Time: \_\_\_\_\_ AM PM

2. Where did the collision occur? City/Town: \_\_\_\_\_ State \_\_\_\_\_

3. Please describe in detail how your collision occurred? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. Were you the:       driver       passenger       pedestrian

5. If passenger, were you in the:    front seat    right rear seat    left rear seat

6. What type of vehicle were you in? \_\_\_\_\_

7. What type was the other vehicle? \_\_\_\_\_

8. Did your vehicle strike the other vehicle?    yes    no

9. Was your car struck by the other vehicle?    yes    no

10. Was the impact from:    the front    the rear    the left side    the right side

11. What was the approximate speed at the time of the impact?

Your vehicle \_\_\_\_\_ mph      Other vehicle \_\_\_\_\_ mph

12. How much damage was done to **your** vehicle \$ \_\_\_\_\_ The other vehicle \$ \_\_\_\_\_    Not Sure

13. What was the weather at the time of the collision?    dry    wet    icy

14. Was your vehicle in:    park    neutral    in gear    moving    stopped

15. Were your brakes being applied?    yes    no

16. Was your vehicle shoved:    forward    backward    sideways

17. Were you shoved:    forward    whipped backward    sideways

18. Did your seat have a head restraint (headrest?)    yes    no

19. If yes, what was the position?    low    midposition    high

20. Did your head ride over the headrest?    yes    no

21. Did your hat/glasses end up in the back seat or rear window?    yes    no

22. Did any other part of your body hit the interior of the vehicle?    yes    no

23. If yes, please specify:    seatbelt restraints    steering wheel    dashboard

windshield    side door    side window    Other \_\_\_\_\_

27. Which part of your body?    chest    head    chin    face    R L knee

R L shoulder    R L hand    Other \_\_\_\_\_

28. Were you holding on to the steering wheel?  yes  no
29. Did you brace your arms against the dash?  yes  no
30. Did you brace your legs against the floorboard?  yes  no
31. Was your ankle turned?  yes  no
32. Did the vehicle go into a spin or roll as a result of the impact?  yes  no
33. If yes, explain: \_\_\_\_\_
34. At the point of impact, where did you experience pain? Be specific: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
35. Immediately after the accident were you:  conscious  dazed  unconscious
36. What is the next thing you remember immediately after the impact? \_\_\_\_\_  
\_\_\_\_\_
37. If you lost consciousness, how long? \_\_\_\_\_
38. Were you wearing a seat belt?  yes  no
39. Did the belt have a shoulder harness?  yes  no
40. If yes, did it contribute to the pain you are experiencing?  yes  no
41. At the time of impact were you:  looking straight ahead  looking to the right  
 looking to the left  looking down  looking up
43. Did the seat break as a result of the impact?  yes  no
44. Were you braced for the impact?  yes  no
45. Were you surprised by the impact?  yes  no
46. Did you go to the hospital?  yes  no
47. If yes, when?  right after the accident  next day  other: \_\_\_\_\_
48. If yes, how did you get there?  ambulance  other: \_\_\_\_\_
49. If by ambulance, did the ambulance attendants place you in a:  neck brace  back brace  
 Other: \_\_\_\_\_
50. Any medication or medical supplies given? \_\_\_\_\_
51. Did you have x-rays taken at the hospital?  yes  no
52. If you went to the hospital, please answer the following:  
Name of hospital \_\_\_\_\_  
Name of doctor \_\_\_\_\_  
Diagnosis \_\_\_\_\_  
Treatment Received \_\_\_\_\_  
\_\_\_\_\_
53. Did you consult any other doctors prior to coming to this office?  yes  no
54. If yes, who and type of doctor/therapist? \_\_\_\_\_  
\_\_\_\_\_

55. What treatment did you receive? \_\_\_\_\_

56. Did the treatment help? \_\_\_\_\_

57. Describe the doctor's diagnosis? \_\_\_\_\_

58. Are you still under a doctor's care?  yes  no If yes, please explain: \_\_\_\_\_

59. If no, when were you last treated? \_\_\_\_\_

**Past History:**

1. Have you ever injured this area before?  yes  no If yes, when? \_\_\_\_\_

2. Have you been involved in any previous accidents of any kind (personal injury, automobile collision or worker's compension)?  yes  no If yes, please explain dates and details \_\_\_\_\_

3. Have you enjoyed good health prior to this accident?  yes  no If no, please explain: \_\_\_\_\_

**Present Information/Disability:**

1. Have you returned to work? \_\_\_\_\_, If yes, date returned to work \_\_\_\_\_

2. Job description \_\_\_\_\_

3. Are your work activities restricted as a result of this accident? \_\_\_\_\_, If yes, please explain: \_\_\_\_\_

4. Do you notice any activity restrictions as a result of this injury? \_\_\_\_\_, If yes, please describe: \_\_\_\_\_

5. Since this injury are your symptoms:  improving  getting worse  staying the same  
Please explain: \_\_\_\_\_

I certify that I have read and understand the above information. To the best of my knowledge the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

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

Witness \_\_\_\_\_ Date \_\_\_\_\_