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AUTO ACCIDENT QUESTIONNAIRE

1. NAME: _____

2. DATE OF BIRTH: _____

3. DATE OF CONSULT: _____

4. DATE OF ACCIDENT: _____

5. NAMES OF TREATING DOCTORS:
_____
_____
_____

6. TYPE AND YEAR OF VEHICLE PATIENT IN:
_____

7. TYPE AND YEAR OF OTHER VEHICLE INVOLVED:
_____

8. LOCATION OF THE ACCIDENT:
_____

9. YOUR VEHICLE WAS STRUCK FROM: THE REAR, FRONT, LEFT SIDE, OR RIGHT SIDE?
_____

10. DID YOU STRIKE YOUR HEAD IN THE ACCIDENT? _____
IF YES, ON WHAT?_____
_____
_____

11. DID YOU HAVE ANY BRUISES OR CUTS ON YOUR BODY AFTER THE ACCIDENT FROM THE SEATBELT OR FROM STRIKING YOUR BODY? Yes ___ No ___
IF YES, WHERE: _____
_____
_____

AUTO ACCIDENT QUESTIONNAIRE

12. DID YOU HIT YOUR HEAD ON THE HEADREST? _____

13. DID THE AIRBAG DEPLOY ON YOUR VEHICLE? _____
OR THE OTHER VEHICLE? _____

14. WAS YOUR CAR DRIVEABLE? _____

15. WHAT WAS THE DOLLAR AMOUNT OF DAMAGE TO YOUR VEHICLE? _____

16. DID YOU SEE THE OTHER VEHICLE COMING? _____

17. DID YOU SEE THE OTHER DRIVER'S FACE? _____

18. DID YOU HEAR THE SQUEAL OF BRAKES? _____

19. WHEN YOU WERE HIT, HOW FAR WERE YOU PUSHED FORWARD? _____

20. DID YOU STRIKE ANYTHING ELSE AFTER YOU WERE PUSHED? _____
_____

21. WAS THERE A SECOND COLLISION WITH A CURB OR ANOTHER CAR?
_____

22. WERE YOU CONSCIOUS THE WHOLE TIME? _____
IF NOT, HOW LONG WERE YOU UNCONSCIOUS? _____
_____

23. WERE YOU ABLE TO GET OUT OF YOUR CAR ON YOUR OWN? _____
_____
_____

24. WERE YOU STEADY ON YOUR FEET WHEN YOU GOT OUT? _____

25. DID EMS COME? _____

DID YOU USE EMS? _____

DO YOU REMEMBER EMS? _____

26. DID YOU GO TO AN EMERGENCY ROOM? _____
IF SO, WHERE? _____ WHEN? _____? HOW? _____

27. HOW LONG WERE YOU IN THE EMERGENCY ROOM? _____

AUTO ACCIDENT QUESTIONNAIRE

28. WERE YOU ADMITTED TO THE HOSPITAL? _____
IF SO, FOR HOW LONG? _____

29. HAVE YOU HAD CTs? _____

OF WHAT? _____
WHERE? _____
WHEN? _____

30. HAVE YOU HAD MRIs? _____

OF WHAT? _____
WHERE? _____
WHEN? _____

31. DID YOU TAKE THERAPY OR TREATMENTS? _____

WITH WHOM? _____

HOW MANY TIMES? _____

DID IT HELP? _____

32. WERE YOU ON MEDICATION? _____

TYPE AND DOSAGE: _____

33. DO YOU HAVE NECK PAIN? _____
IF YES, FILL OUT NECK QUESTIONNAIRE.

33. DO YOU HAVE HEADACHES? _____
IF YES, FILL OUT THE HEADACHE QUESTIONNAIRE.

34. DO YOU HAVE LOWBACK PAIN? _____
IF YES, FILL OUT HEADACHE QUESTIONNAIRE.

35. DID YOU HAVE A CONCUSSION? _____
IF YES, FILL OUT THE CONCUSSION QUESTIONNAIRE.

36. ARE YOU GETTING BETTER OR WORSE? _____
IF WORSE, HOW AND WHY: _____