Name: _____ Today:

AUTO ACCIDENT QUESTIONNAIRE

History of Injury:

Were you the: ☐ Driver ☐ Front Passenger ☐ Back Passenger ☐ On the Job
Description of vehicle you were in: Make _____ Model _____ Year _____
Transmission Type: ☐ Standard (Stick) ☐ Automatic **Braced yourself with:** ☐ Arms ☐ Legs ☐ Not at all

Portion of vehicle hit: ☐ Front Right ☐ Rear Right ☐ Side Right ☐ Swipe **Intersection of?** _____
☐ Front Left ☐ Rear Left ☐ Side Left ☐ T Type
☐ Front Center ☐ Rear Center

Was your vehicle stopped at the time of the impact? [Y] [N] ☐ Sign ☐ Light ☐ Traffic **If no, your speed:** _____ MPH
Was your foot on the brake? [Y] [N] ☐ Right ☐ Left ☐ Both **Lap Belt worn?** [Y] [N] **Shoulder Belt worn?** [Y] [N]
Were your hands on the steering wheel? [Y] [N] ☐ Right ☐ Left ☐ Both
Description of other vehicle: Make _____ Model _____ Year _____
Estimated rate of speed of the other vehicle _____ MPH **Was anyone cited?** [Y] [N] **Who?** _____
Road Conditions: ☐ Dry ☐ Damp ☐ Wet ☐ Snow ☐ Ice ☐ Other _____
How far did your car move after impact? _____
Have you received an estimate on your car yet? [Y] [N] **If yes, amount of damage?** ($ or 1 -10) _____
Amount of damage to at fault? ($ or 1 -10) _____
Head Position: ☐ Off head rest more than 2 inches ☐ Back against head rest ☐ Doesn't recall
Did you have on a hat or have your hair up? [Y] [N] **Were your hat/eyeglasses still on after impact?** [Y] [N]
Were you looking: ☐ Forward ☐ Head tilted ☐ Turned Right ☐ Turned Left ☐ Leaning full body forward ☐ Leaning back
Position of Head rest: ☐ Up ☐ Down ☐ Doesn't recall Number of inches above or below top of head? _____
Seat Position: ☐ Leaning forward (80°) ☐ Straight up (90°) Leaning back: ☐ 100° ☐ 120° ☐ 140° ☐ doesn't recall
Was the seat broken after the accident? [Y] [N]
Did the Air Bag deploy? [Y] [N] **If yes, you were:** ☐ Struck ☐ Not Struck
Immediately following the accident I was: ☐ Dazed ☐ Rendered Unconscious ☐ Doesn't remember details clearly
☐ Nauseated ☐ Emotionally distraught ☐ Other _____

After the accident I went: ☐ Home ☐ Work ☐ Hospital ☐ Family Physician ☐ Other _____
By: ☐ Private car ☐ Ambulance ☐ Treated at the scene
Did you hit anything inside the vehicle? [Y] [N] **If yes, what?** ☐ Gear shift ☐ Steering wheel ☐ Windshield ☐ Dash
With what? ☐ Head ☐ Knee ☐ Hand ☐ Shoulder ☐ Other _____
Did you have any cuts from the accident? [Y] [N] **Bruises?** [Y] [N]
If yes, where? _____
Have you returned to work since the accident? [Y] [N] **If yes, how affected?** _____

Chief Complaint:

☐ Lower back ☐ Upper back ☐ Mid back ☐ Headaches ☐ Between shoulder blades ☐ Neck pain ☐ Other _____
Symptoms first appeared: ☐ Immediately ☐ Hours after the accident ☐ The next day ☐ Days later (# of days _____)

My pain began: ☐ Gradually ☐ Suddenly **Pain is:** ☐ Constant 100% ☐ Frequent 75% ☐ Occasional 50% ☐ Intermittent 25%

The Intensity is: <MILD> 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 <SEVERE>
My pain is worse when I: ☐ Cough ☐ Sit ☐ Walk ☐ Push ☐ Stand for long periods ☐ First wake up
☐ Sneeze ☐ Bend ☐ Lift ☐ Pull ☐ Lie down ☐ Getting up/Down

Does anything make the pain worse? _____

The sensation is: ☐ Shooting ☐ Aching ☐ Burning ☐ Stiffness ☐ Stabbing ☐ Numbness
☐ Dull ☐ Sharp ☐ Throbbing ☐ Cramping ☐ Pins & Needles ☐ Other_____

Pain goes into: ☐ Left Leg ☐ Left Arm ☐ Back of head **Type of pain:** ☐ Shooting ☐ Numbing ☐ Pins & Needles
☐ Right Leg ☐ Right Arm ☐ Stays in one place ☐ Stabbing ☐ Aching ☐ Other _____

Since the accident, condition is getting: ☐ Better ☐ Worse ☐ Staying about the same
Pain has woken you up during the night? [Y] [N] **Weather changes affect pain?** [Y] [N]
What home remedies are you doing for the pain? _____
Has pain affected your daily living in any way?

☐ Working	☐ Bending over	☐ Playing with kids	☐ Using Bathroom
☐ Sleeping	☐ Reaching over head	☐ Driving	☐ Cooking
☐ Sitting	☐ Cleaning house	☐ Exercising	☐ Standing
☐ Walking	☐ Brushing teeth	☐ Shopping	☐ Lifting