AUTO ACCIDENT / INJURY QUESTIONNAIRE

Name_____ Date_____

Date of Accident _____ Time of Accident _____ am pm

About the Accident

Were you the: ☐ Driver ☐ Front Passenger ☐ Rear Passenger

Make and model of the vehicle you were occupying?_____

Total # of people in the vehicle: _____

Were the police notified? ☐ yes ☐ no

Was a police report filed? ☐ yes ☐ no

Were citations issued at the scene? ☐ yes ☐ no

Were there any witnesses? ☐ yes ☐ no

Were you wearing a seat belt? ☐ yes ☐ no If yes, ☐ lap/shoulder belt ☐ lap belt only

Was the vehicle equipped with airbags? ☐ yes ☐ no If yes, did they deploy? ☐ yes ☐ no

Did any part of your body strike anything inside the vehicle? ☐ yes ☐ no If yes, describe _____ _____

What did your vehicle impact? ☐ another vehicle ☐ other _____

Name of the street/location on which you were traveling?_____

Direction you were traveling? ☐ N ☐ S ☐ E ☐ W

Approximate speed of your vehicle? _____ mph

If you were moving, were you: ☐ at a steady speed ☐ slowing down ☐ braking for the accident

Amount of traffic at the time of the accident? ☐ light ☐ moderate ☐ heavy

Weather conditions at time of accident? ☐ clear / dry ☐ wet / rainy ☐ overcast / dry

During the impact, which direction were your facing? ☐ Forward ☐ Right ☐ Left

What part of your vehicle was impacted? ☐ Right side ☐ Left side ☐ Front ☐ Rear ☐ Other

Were you aware or surprised by the impact? ☐ Aware ☐ Surprised

Make and model of other vehicle(s) involved?_____

Direction other vehicle(s) were traveling? ☐ N ☐ S ☐ E ☐ W

Approximate speed of other vehicle(s)? _____ mph

Briefly describe in your own words what happened: _____

_____

_____

_____

_____

After the accident

Did you lose consciousness after the impact? ☐ yes ☐ no If so, for how long? _____

Describe briefly how you felt after the accident: _____

_____

Did you receive emergency care at the scene? ☐ yes ☐ no If yes, describe:_____

_____

Where did you go immediately after the accident? ☐ home ☐ work ☐ emergency room ☐ other _____

Have you gone to the hospital or seen any other doctor? ☐ yes ☐ no
If yes, list name of hospitals and/or doctors along with dates:

_____

_____

Describe any treatment you have received: _____

_____

_____

Were X-rays taken? ☐ yes ☐ no

Was medication prescribed? ☐ yes ☐ no

Have you been able to work since this injury? ☐ yes ☐ no

Are your work activities restricted since this injury? ☐ yes ☐ no

Check the symptoms you have experienced since the accident:

☐ Headaches	☐ Shoulder pain	☐ Fatigue	☐ Blurred vision
☐ Neck pain	☐ Tension across shoulders	☐ Dizziness	☐ Ringing in ears
☐ Neck stiffness	☐ Arm /hand pain	☐ Memory loss	☐ Shortness of breath
☐ Back pain	☐ Numbness in arms/hands/fingers	☐ Difficulty sleeping	☐ Chest pain
☐ Back stiffness	☐ Leg/foot pain	☐ Irritability	☐ Stomach upset
☐ Low back pain	☐ Numbness in legs/feet/toes	☐ Nausea	☐ Other _____

Is your condition getting worse? ☐ yes ☐ no

Is your condition aggravated by any of the following?

☐ Sitting	☐ Lying on back	☐ Working	☐ Pulling
☐ Standing	☐ Lying on side	☐ Lifting	☐ Reaching
☐ Walking	☐ Lying on stomach	☐ Bending	☐ Stretching
☐ Running	☐ Resting	☐ Kneeling	☐ Other _____

Please provide any additional information that we should know: _____

_____

_____

_____

_____ _____ _____

Patient Name (printed) Patient Signature Date