

Automobile/Accident Questionnaire

Patient Name: _____ **Date:** _____

VEHICLE YOU WERE IN

Vehicle type?

- Car Pickup Van Truck Station Wagon
 Bus Other _____

Vehicle size?

- Subcompact Full-Size Compact Mini
 Mid-Size Light Other _____

What was your location in the vehicle?

- Driver Front Passenger Rear Passenger
 Passenger Location: Left Middle Right
 Other _____

What was the vehicle you were in doing?

Mark only one box for the above question

- Vehicle stopped for** Traffic Light Intersection
 Stop Sign Traffic Pedestrian Parked
 Other _____

Vehicle slowing down for Traffic Light Intersection

- Stop Sign Traffic Pedestrian Turning
 Parking Other _____

Vehicle moving Slowly Moderately Fast

- _____ MPH Accelerating
 Other _____

What damage did the vehicle you were in sustain?

- Minimal Moderate Extensive Totaled
 Unsure Other _____

What damage did this vehicle sustain?

- Minimal Moderate Extensive Totaled
 Unsure Other _____

Second vehicle to strike the vehicle you were in

- Vehicle type?** Car Pickup Van Truck
 Station Wagon Bus Other _____

Vehicle size? Subcompact Full-Size Compact

- Mini Mid-Size Light
 Other _____

How did this vehicle strike the vehicle you were in?

- Head On From Right From Left
 Rear Ended Sideswiped on Right
 Sideswiped on Left
 Other _____

What damage did this vehicle sustain?

- Minimal Moderate Extensive Totaled
 Unsure Other _____

Describe other vehicles to strike the vehicle you were in

- Vehicle Type: _____
 How it struck: _____
 Vehicle Size: _____
 Damage: _____

Were traffic citations issued as a result of the accident?

- No citations issued Driver of other vehicle
 Driver of vehicle you were in You
 Unsure

IF OTHER VEHICLES INVOLVED IN ACCIDENT

First vehicle to strike vehicle you were in

- Vehicle type?** Car Pickup Van Truck
 Station Wagon Bus Other _____

Vehicle size? Subcompact Full-Size Compact

- Mini Mid-Size Light
 Other _____

How did this vehicle strike the vehicle you were in?

- Head On From Right From Left
 Rear Ended Sideswiped on Right
 Sideswiped on Left
 Other _____

AT MOMENT OF IMPACT

Were you prepared for the accident?

- Accident was a complete surprise
 Aware of impending collision
 Braced for impact

Was your foot on the brake pedal at impact?

- Yes No

Were you wearing a restraint belt?

- Yes No

What type of restraint belt were you wearing?

- Shoulder-Lap Belt Shoulder Belt Lap Belt

Was your vehicle equipped with air bags?

- Yes No Unsure

Did the airbags deploy?

- Yes No

What was your body position at impact?

- Straight Slouched Forward
ROTATED: Right Left Don't Recall
 Other _____

What direction was your body thrown?

- Forward/Backward Backward/Forward
 Sideways Outside Vehicle
 Under Vehicle Don't Recall
 Other _____

What position were your head/neck at impact?

- Straight Tilted Forward
ROTATED: Right Left Don't Recall
 Other _____

Through what motion were your head/neck pitched?

- Forward/Backward Backward/Forward
 Sideways Don't Recall
 Other _____

Where in items/people dislodged or displaced in your car at time of impact?

For example: Drink spilled/ejected, glasses thrown off, purse or other items in seat thrown to floor or items thrown out of dashboard/center console.

Please list and explain:

Accident/Injury Questionnaire

Patient Name: _____ **Date:** _____

DATE AND TIME OF ACCIDENT/INJURY

Date: ___/___/___ Time: _____am/pm

IMMEDIATELY AFTER ACCIDENT/INJURY

Did you lose consciousness?

Yes No Don't Know

How did you feel?

Confused Dazed Dizzy Nervous
 Weak Other _____

Where did you immediately develop pain?

Head R L Shoulder R L Buttocks
 Neck R L Arms R L Hips
 Upper/Mid Back R L Elbows R L Thighs
 Lower Back R L Forearms R L Knees
 Pelvis R L Wrists R L Legs
 Chest/Rib Cage R L Hands R L Ankles
 Abdomen R L Feet
 Other _____

If there were cuts or bruising, where were they?

Head R L Shoulder R L Buttocks
 Neck R L Arms R L Hips
 Upper/Mid Back R L Elbows R L Thighs
 Lower Back R L Forearms R L Knees
 Pelvis R L Wrists R L Legs
 Chest/Rib Cage R L Hands R L Ankles
 Abdomen R L Feet
 Other _____

Emergency Care At Accident/Injury Site

Did you receive emergency care?

Yes No

Destination After Accident/Injury

Where did you go?

Hospital Home School Work
 Urgent Care Primary Care
 Other _____

By whom were you driven?

Myself Ambulance Friend
 Family Member
 Other _____

HOSPITAL VISIT AFTER ACCIDENT/INJURY

What treatment was administered at the hospital?

Oral Medication Sutures Splint
 Collar Injection Ice Packs
 Casts Support Bandages
 Hot Packs Brace Surgery
 Topical Antiseptics Other _____

Instructions Given When Discharged From Hospital

Were you told to see?

General Practitioner Chiropractor Neurologist
 Physical Therapist Orthopedist Internist
 General Surgeon Plastic Surgeon
 Other _____

What recommendations were made?

No Further Care No Follow-Up Instructions
 Observation Rest Ice
 Heat Collar Support
 Time Off Work Other _____

Were medications prescribed?

Pain Anti-Inflammatory Antibiotic
 Nervousness Other _____

FOLLOWING THE ACCIDENT/INJURY

Since your accident/injury have you suffered from?

Blurred Vision Chest Pain Nausea
 Double Vision Vomiting Difficulty Breathing
 Reduced Vision Palpitations Frequent Urination
 Impaired Hearing Constipation Inability to hold urine
 Ringing in Ears Diarrhea Painful Urination

Additionally have you experienced any of the following?

Anxiety Convulsions Restlessness
 Depression Dizziness Insomnia
 Mood Swings Headaches Light Sensitivity
 Nervousness Fainting Reduced Appetite
 Poor Memory Tension Weakness
 Loss of Balance Fatigue Weight Gain
 Weight Loss
 Other _____

FOLLOWING THE ACCIDENT/INJURY

How much later did additional symptoms develop?

- Immediately Hours That Evening
 Next Morning Days Week
 Month Other _____

What additional symptoms developed?

Head

- Pain Stiffness Numbness Tingling
 Other _____

Jaw

- Pain Stiffness Numbness Tingling
 Other _____

Neck

- Pain Stiffness Numbness Tingling
 Other _____

Upper/Middle Back

- Pain Stiffness Numbness Tingling
 Other _____

Lower Back

- Pain Stiffness Numbness Tingling
 Other _____

Pelvis

- Pain Stiffness Numbness Tingling
 Other _____

Chest/Rib Cage

- Pain Stiffness Numbness Tingling
 Other _____

Abdomen

- Pain Stiffness Numbness Tingling
 Other _____

Shoulder

- R L Pain R L Stiffness R L Numbness
 R L Tingling Other _____

Arms

- R L Pain R L Stiffness R L Numbness
 R L Tingling Other _____

Elbows

- R L Pain R L Stiffness R L Numbness
 R L Tingling Other _____

Forearms

- R L Pain R L Stiffness R L Numbness
 R L Tingling Other _____

Wrists

- R L Pain R L Stiffness R L Numbness
 R L Tingling Other _____

Hands/Fingers

- R L Pain R L Stiffness R L Numbness
 R L Tingling Other _____

Buttocks

- R L Pain R L Stiffness R L Numbness
 R L Tingling Other _____

Hips

- R L Pain R L Stiffness R L Numbness
 R L Tingling Other _____

Thighs

- R L Pain R L Stiffness R L Numbness
 R L Tingling Other _____

Knees

- R L Pain R L Stiffness R L Numbness
 R L Tingling Other _____

Legs

- R L Pain R L Stiffness R L Numbness
 R L Tingling Other _____

Ankles

- R L Pain R L Stiffness R L Numbness
 R L Tingling Other _____

Feet/Toes

- R L Pain R L Stiffness R L Numbness
 R L Tingling Other _____

FOLLOWING THE ACCIDENT/INJURY

Are you restricted in any of the following areas as a result of this accident/injury?

- Daily Living Occupational/Work
 Recreational Activities Other _____

Have you missed work due to this accident/injury?

- Missed No Work Limited Work Activity
 Missed Work From: ___/___/___ To ___/___/___
 Other _____

Did you self treat your symptoms?

- Ice Heat Bed Rest
 Over-The-Counter Medication
 Other _____

Did you seek medical care elsewhere?

Medical Doctor Name: _____

Diagnosis and Treatment Recommendation:

Chiropractor (other than here) Name: _____

Diagnosis and Treatment Recommendation:

