

AUTOMOBILE ACCIDENT QUESTIONNAIRE

Patient's Name: _____ **Today's Date:** _____

Date of Accident: _____ **Time of Accident:** _____ AM PM

Location of Accident: _____

City: _____ **County:** _____ **State:** _____

THE FOLLOWING QUESTIONS PERTAIN TO YOU AND THE VEHICLE YOU WERE IN:

Where were you in the vehicle?

- | | | |
|--|--|--------------------------------------|
| <input type="checkbox"/> Driver's Front Seat | <input type="checkbox"/> Passenger Side Rear | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Driver's Side Rear Seat | <input type="checkbox"/> Front Middle Seat | |
| <input type="checkbox"/> Passenger Side Front | <input type="checkbox"/> Rear Middle Seat | |

Vehicle type:

- | | | |
|---|---|---|
| <input type="checkbox"/> Compact car | <input type="checkbox"/> Mini van | <input type="checkbox"/> Full size pickup truck |
| <input type="checkbox"/> Mid sized car | <input type="checkbox"/> Passenger van | <input type="checkbox"/> Utility work truck |
| <input type="checkbox"/> Full sized car | <input type="checkbox"/> Full size sports utility | <input type="checkbox"/> Motorcycle |
| <input type="checkbox"/> Station wagon | <input type="checkbox"/> Compact pickup truck | <input type="checkbox"/> Other _____ |

Speed of your vehicle:

- | | | |
|----------------------------------|--|--|
| <input type="checkbox"/> Stopped | <input type="checkbox"/> Moving Slowly | <input type="checkbox"/> Moving at approximately _____ MPH |
| <input type="checkbox"/> Parked | <input type="checkbox"/> Moving Moderately | |
| <input type="checkbox"/> Slowing | <input type="checkbox"/> Accelerating | |

What was your vehicle doing prior to impact:

- | | |
|--|--|
| <input type="checkbox"/> Changing lanes | <input type="checkbox"/> Coming to or at a traffic light |
| <input type="checkbox"/> Merging | <input type="checkbox"/> Car in front suddenly slowed or stopped |
| <input type="checkbox"/> Yielding | <input type="checkbox"/> Parallel parking |
| <input type="checkbox"/> Driving straight ahead | <input type="checkbox"/> Turning at intersection |
| <input type="checkbox"/> Experiencing traffic congestion | <input type="checkbox"/> Turning into driveway or parking lot |
| <input type="checkbox"/> Coming to or at a stop sign | <input type="checkbox"/> Other _____ |

What was your vehicle's point of impact:

- | | | | |
|---|--|---|--------------------------------------|
| <input type="checkbox"/> Front & rear bumpers | <input type="checkbox"/> Left front fender | <input type="checkbox"/> Rear bumper | <input type="checkbox"/> Right side |
| <input type="checkbox"/> Front bumper | <input type="checkbox"/> Left rear fender | <input type="checkbox"/> Right front fender | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Front driver's side | <input type="checkbox"/> Left side | <input type="checkbox"/> Right rear fender | |

Amount of financial damage to your vehicle:

- | | | |
|---|---|-----------------------------------|
| <input type="checkbox"/> Unknown | <input type="checkbox"/> Minimal, barely noticeable | <input type="checkbox"/> \$ _____ |
| <input type="checkbox"/> Unknown at this time | <input type="checkbox"/> Totaled | |

Road conditions:

- | | | | | |
|---|-------------------------------|--------------------------------|--------------------------------------|--------------------------------------|
| <input type="checkbox"/> Gravel | <input type="checkbox"/> Dry | <input type="checkbox"/> Icy | <input type="checkbox"/> Slushy | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Debris on road | <input type="checkbox"/> Fair | <input type="checkbox"/> Muddy | <input type="checkbox"/> Snow packed | |
| <input type="checkbox"/> Damp | <input type="checkbox"/> Good | <input type="checkbox"/> Sandy | <input type="checkbox"/> Wet | |

Visibility:

- | | | |
|--|---|--|
| <input type="checkbox"/> Clear | <input type="checkbox"/> Reduced at dawn | <input type="checkbox"/> Reduced due to fog |
| <input type="checkbox"/> Cloudy | <input type="checkbox"/> Reduced at dusk | <input type="checkbox"/> Reduced due to rain |
| <input type="checkbox"/> Bright sunlight | <input type="checkbox"/> Reduced at night | <input type="checkbox"/> Reduced due to snow |

Was another vehicle involved: Yes No **How many other vehicles:** _____

Explain which vehicle hit the other:

- | | |
|---|---|
| <input type="checkbox"/> The other vehicle hit my vehicle | <input type="checkbox"/> My vehicle hit the other vehicle |
| <input type="checkbox"/> More than one vehicle hit my vehicle | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Car behind pushed me into car in front | _____ |

Was a police report filed: Yes No Not yet

Citations:

- | | | |
|--------------------------------------|---|--|
| <input type="checkbox"/> None issued | <input type="checkbox"/> Driver of vehicle I was a passenger of | <input type="checkbox"/> Driver of other vehicle |
| <input type="checkbox"/> Myself | | <input type="checkbox"/> Not sure |

THE FOLLOWING QUESTIONS ARE CONCERNING YOU AT THE MOMENT OF IMPACT:

Were the air bags deployed: Yes No

Position of the headrest:

- | | | |
|--|---|--------------------------------------|
| <input type="checkbox"/> Adjusted high | <input type="checkbox"/> All the way down | <input type="checkbox"/> No headrest |
| <input type="checkbox"/> Adjusted low | <input type="checkbox"/> All the way up | <input type="checkbox"/> Other _____ |

Type of seat restraint:

- | | | |
|--|--|--|
| <input type="checkbox"/> Carseat | <input type="checkbox"/> Lap belt only | <input type="checkbox"/> No seat belts |
| <input type="checkbox"/> Shoulder harness only | <input type="checkbox"/> Shoulder harness and lap belt | <input type="checkbox"/> Other _____ |

Were you prepared for the impact: Yes No

Was your foot on the brake at the time of impact: Yes No

If yes, was your foot knocked off the pedal upon impact: Yes No

What was the position of your head and neck prior to impact:

- | | | |
|--|---|--|
| <input type="checkbox"/> Down | <input type="checkbox"/> Straight ahead | <input type="checkbox"/> Up |
| <input type="checkbox"/> Down and to the left | <input type="checkbox"/> Level and to the left | <input type="checkbox"/> Up and to the left |
| <input type="checkbox"/> Down and to the right | <input type="checkbox"/> Level and to the right | <input type="checkbox"/> Up and to the right |

Did you lose consciousness after injury: Yes No

Did you receive emergency care at the scene: Yes No

Where did you go immediately after the accident: _____

Describe how you felt immediately after the accident: _____

Patient's Signature: _____