AUTOMOBILE ACCIDENT QUESTIONNAIRE

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

Date of Accident:_____ Claim Number _____

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

Vehicle type:

❑Car ❑Pickup
❑Van ❑Commercial Truck
❑Station Wagon ❑Sports Utility Vehicle
❑Other_____

Vehicle size:

❑Subcompact Car ❑Pickup - small
❑Compact Car ❑Pickup - large
❑Mid-size Car ❑Sports Utility-small
❑Large Car ❑Sports Utility-large

Your position in the vehicle:

❑Driver
❑Front Passenger ❑Rear Passenger ❑Third Seat (rear)
Passenger Location--------❑Driver's side ❑Middle ❑Passenger's Side

Speed of your vehicle:

❑Stopped ❑Accelerating
❑Parked ❑Moving approximately_____miles per hour
❑Slowing

Why Vehicle was slowed or stopped:

❑Traffic Signal ❑Parking
❑Pedestrian ❑Traffic
❑Stop Sign ❑Busy Intersection

Collision Type:

❑Driver Side Impact ❑Rear and Front
❑Passenger Side Impact ❑Rear Impact
❑Front Impact ❑Pedestrian Incident

THE FOLLOWING QUESTIONS CONCERN THE OTHER VEHICLE INVOLVED IN THE ACCIDENT:

Vehicle type:

❑Car ❑Pickup
❑Passenger Van ❑Commercial Truck
❑Station Wagon ❑Sports Utility Vehicle
❑Other_____

Vehicle size:

❑Subcompact Car ❑Pickup - small
❑Compact Car ❑Pickup-large
❑Mid-size Car ❑Sports Utility-small
❑Large Car ❑Sports Utility-large

CONDITIONS AT THE TIME OF THE ACCIDENT:

Time of day:

❑Full daylight
❑Dawn
❑Dusk
❑Night

Road Conditions:

❑Dry
❑Damp
❑Wet
❑Snow covered
❑Ice covered
❑Patchy Ice/Snow

Visibility:

❑Excellent
❑Good
❑Fair
❑Poor

Visibility compromised by:

❑Brightness
❑Darkness
❑Rain
❑Snow
❑Fog
❑Traffic

THE FOLLOWING QUESTIONS CONCERN THE MOMENT OF IMPACT OF THE ACCIDENT:

Were you...

❑Totally unaware that the accident was impending
❑Aware that the accident was impending
❑Aware that the accident was impending and braced for it

Restraints: (check all that apply)

❑Seat belt
❑Shoulder harness
❑No restraints

If you were the driver of the vehicle, was your foot on the brake pedal? ❑Yes ❑No ❑Knocked off by impact

Was the air bag deployed?

❑Car not equipped with air bag
❑Air bag deployed
❑Air bag not deployed

What position was YOUR headrest in?

❑High position-top of headrest even with top of head
❑Middle position-top of headrest even with middle of neck
❑ Low position-top of headrest even with shoulders

Was your vehicle pushed forward from the impact? ❑ no ❑ yes, if yes How far was your vehicle pushed forward? ❑ one car length ❑ more than one car length ❑ one-half car length ❑ less than one-half car length

Position of YOUR head at time of impact?

❑Facing straight ahead
❑Tilted forward
❑Rotated to the left
❑Rotated to the right

Was your head thrown...?

❑Backward and then forward
❑Forward then backward
❑To the left ❑To the left then the right
❑To the right ❑To the right, then the left

Position of Your body at time of impact?

❑Straight
❑Tilted forward
❑Rotated to the left
❑Rotated to the right

Was your body thrown...?

❑Backward and then forward
❑Forward then backward
❑To the left ❑To the left then the right
❑To the right ❑To the right, then the left

Damage to vehicle YOU were in:

❑Incurred minimal damage-$_____
❑Incurred moderate damage $_____
❑Incurred severe damage $_____
❑Was totaled $_____
❑Not known

Citations:

❑None issued
❑Yourself
❑Driver of vehicle patient was a passenger of
❑Driver of other vehicle
❑Not sure

AS A RESULT OF THE FORCE OF THE COLLISION WHICH OBJECTS IN THE VEHICLE DID YOUR BODY STRIKE

Head

❑Steering wheel ❑Right door
❑Dashboard ❑Left window
❑Windshield ❑Right window
❑Armrest ❑Console
❑Headrest ❑Gear shift
❑Rear view mirror ❑Front of seat
❑Left door ❑Back of seat
❑ Air bag

Left Arm

❑Steering wheel ❑Right door
❑Dashboard ❑Left window
❑Windshield ❑Right window
❑Armrest ❑Console
❑Headrest ❑Gear shift
❑Rear view mirror ❑Front of seat
❑Left door ❑Back of seat
❑ Air bag

Right Arm

❑Steering wheel ❑Right door
❑Dashboard ❑Left window
❑Windshield ❑Right window
❑Armrest ❑Console
❑Headrest ❑Gear shift
❑Rear view mirror ❑Front of seat
❑Left door ❑Back of seat
❑ Air Bag

Torso

❑Steering wheel ❑Right door
❑Dashboard ❑Left window
❑Windshield ❑Right window
❑Armrest ❑Console
❑Headrest ❑Gear shift
❑Rear view mirror ❑Front of seat
❑Left door ❑Back of seat
❑ Air Bag

Left Leg

❑Steering wheel ❑Right door
❑Dashboard ❑Left window
❑Windshield ❑Right window
❑Armrest ❑Console
❑Headrest ❑Gear shift
❑Rear view mirror ❑Front of seat
❑Left door ❑Back of seat
❑ Air Bag

Right Leg

❑Steering wheel ❑Right door
❑Dashboard ❑Left window
❑Windshield ❑Right window
❑Armrest ❑Console
❑Headrest ❑Gear shift
❑Rear view mirror ❑Front of seat
❑Left door ❑Back of seat
❑ Air Bag

THE FOLLOWING QUESTIONS CONCERN THE TIME PERIOD IMMEDIATELY FOLLOWING THE ACCIDENT:

Did you lose consciousness?

❑Yes
❑No

Immediately following the accident, did you feel...?

❑Dizzy ❑Weak
❑Dazed ❑Nervous
❑Disoriented ❑Nauseated

Were you able to walk unaided?

❑Yes
❑No

Where did you go...?

❑Drove home ❑Drove to work
❑Was driven home ❑Was driven to work
❑Drove to hospital ❑Drove to school
❑Was driven to hospital ❑Was driven to school
❑Taken to hospital via ambulance

In what areas did you IMMEDIATELY feel pain?

❑Head	Shoulder	❑Left	❑Right	Hip	❑Left	❑Right
❑Neck	Arm	❑Left	❑Right	Thigh	❑Left	❑Right
❑Upper back	Elbow	❑Left	❑Right	Knee	❑Left	❑Right
❑Mid back	Wrist	❑Left	❑Right	Calf	❑Left	❑Right
❑Ribs	Hand	❑Left	❑Right	Ankle	❑Left	❑Right
❑Chest	Fingers	❑Left	❑Right	Foot	❑Left	❑Right
❑Abdomen	Buttock	❑Left	❑Right	Toes	❑Left	❑Right

❑Low Back ❑Pelvis

In what areas did you experience lacerations (cuts) or contusions (bruises)?

❑Head	Shoulder	❑Left	❑Right	Hip	❑Left	❑Right
❑Neck	Arm	❑Left	❑Right	Thigh	❑Left	❑Right
❑Upper back	Elbow	❑Left	❑Right	Knee	❑Left	❑Right
❑Mid back	Wrist	❑Left	❑Right	Calf	❑Left	❑Right
❑Ribs	Hand	❑Left	❑Right	Ankle	❑Left	❑Right
❑Chest	Fingers	❑Left	❑Right	Foot	❑Left	❑Right
❑Abdomen	Buttock	❑Left	❑Right	Toes	❑Left	❑Right

❑Low Back ❑Pelvis

At the hospital, what areas were x-rayed?

❑Head	Shoulder	❑Left	❑Right	Hip	❑Left	❑Right
❑Neck	Arm	❑Left	❑Right	Thigh	❑Left	❑Right
❑Upper back	Elbow	❑Left	❑Right	Knee	❑Left	❑Right
❑Mid back	Wrist	❑Left	❑Right	Calf	❑Left	❑Right
❑Ribs	Hand	❑Left	❑Right	Ankle	❑Left	❑Right
❑Chest	Fingers	❑Left	❑Right	Foot	❑Left	❑Right
❑Abdomen	Buttock	❑Left	❑Right	Toes	❑Left	❑Right

❑Low Back ❑Pelvis

Where did you experience pain on the day FOLLOWING the accident?

❑Head	Shoulder	❑Left	❑Right	Hip	❑Left	❑Right
❑Neck	Arm	❑Left	❑Right	Thigh	❑Left	❑Right
❑Upper back	Elbow	❑Left	❑Right	Knee	❑Left	❑Right
❑Mid back	Wrist	❑Left	❑Right	Calf	❑Left	❑Right
❑Ribs	Hand	❑Left	❑Right	Ankle	❑Left	❑Right
❑Chest	Fingers	❑Left	❑Right	Foot	❑Left	❑Right
❑Abdomen	Buttock	❑Left	❑Right	Toes	❑Left	❑Right

❑ Low Back ❑Pelvis

Next day discomfort...?

❑increased ❑decreased ❑same

Did your major complaints exist before the accident?

❑Yes ❑ No

Describe your main complaint: _____

_____

How long has complaint been present: ❑ immediately after accident
❑ within days of accident
❑ other _____

The pain is… ❑ constant
❑ nearly constant
❑ frequent
❑ comes and goes

Symptoms are worse: ❑ morning ❑ afternoon ❑ evening ❑ time of day does not effect pain

How are your symptoms changing? ❑ getting better ❑ getting worse ❑ not changing

What makes the pain worse?

❑ bending ❑ activity in general ❑ sneezing
❑ coughing ❑ lifting ❑ walking
❑ driving ❑ sitting ❑ worse in the cold/damp weather
❑ getting up & down ❑ standing ❑ other _____

Does this complaint interfere with:

❑ nothing ❑ activities of work
❑ sleep ❑ activities of daily living

Mark your activities of daily living or work. Circle the activities that are difficult or painful.

❑ balancing ❑ keyboarding ❑ reaching over head
❑ bending ❑ lifting ❑ sitting
❑ carrying ❑ pulling ❑ standing on concrete
❑ climbing stairs/steps ❑ pushing ❑ walking over rough terrain
❑ driving ❑ reaching ❑ _____

What makes the pain better?

❑ ice ❑ stretching
❑ heat ❑ medication_____
❑ rest ❑ other _____.

Does the pain radiate? ❑ no
If yes where? ❑ upper arm ❑ forearm ❑ hand ❑ left ❑ right
❑ thigh ❑ calf ❑ foot ❑ left ❑ right

Is there numbness? ❑ no
If yes where? ❑ upper arm ❑ forearm ❑ hand ❑ left ❑ right
❑ thigh ❑ calf ❑ foot ❑ left ❑ right

Is there weakness? ❑ no
If yes where? ❑ upper arm ❑ forearm ❑ hand ❑ left ❑ right
❑ thigh ❑ calf ❑ foot ❑ left ❑ right

Have you experienced an unexplained weight loss? ❑ no ❑ yes

Have you experienced changes in bowel or bladder function? ❑ no ❑ yes

Are you taking any prescription medications or over the counter drugs? ❑ no ❑ yes=if yes,
List medications: _____

Has any other physician seen you for THIS complaint? ❑ no ❑ yes=if yes,
Whom? _____.

Since the accident have these symptoms been present?

❑ anxiety ❑ dizziness/fainting ❑ jaw pain or jaw clicking ❑ ringing/buzzing in ears
❑ chest pain ❑ eyes sensitive to light ❑ headaches
❑ depression ❑ fatigue ❑ loss of memory

Have you ever had PRIOR SIMILAR symptoms? ❑ no ❑ yes=if yes,
Describe: _____

Occupation:
- ❑ clerical
- ❑ homemaker
- ❑ logger
- ❑ retired
- ❑ service/retail
- ❑ truck driver
- ❑ mill worker (shift worker? ❑ no ❑ yes)
- ❑ other _____.

Marital status:
- ❑ divorced
- ❑ never married
- ❑ separated
- ❑ widowed
- ❑ married-How many dependent children?_____

Educational level:
- ❑ less than high school
- ❑ high school graduate
- ❑ 1 to 4 years of college
- ❑ vocational school

Have you missed work due to these complaints? ❑ no ❑ yes=if yes,
List dates off work: _____. Have you returned to full duty work? ❑ no ❑ yes

Present conditions and family history:

Mom	Dad	**Self**		Mom	Dad	**Self**	
❑	❑	❑	**Allergies**	❑	❑	❑	Headaches
❑	❑	❑	**Anemia**	❑	❑	❑	Heart disease
❑	❑	❑	**Arthritis**	❑	❑	❑	Hepatitis
❑	❑	❑	**Asthma**	❑	❑	❑	Hiatal Hernia/Acid Reflux
❑	❑	❑	**Back Problems**	❑	❑	❑	High blood pressure
❑	❑	❑	**Cancer**	❑	❑	❑	High cholesterol
❑	❑	❑	**Constipation**	❑	❑	❑	Kidney disease
❑	❑	❑	**Depression**	❑	❑	❑	Osteoporosis
❑	❑	❑	**Diabetes**	❑	❑	❑	Thyroid Problems
❑	❑	❑	**Diarrhea**	❑	❑	❑	Scoliosis
❑	❑	❑	**Fibromyalgia**	❑	❑	❑	Ulcers

Have you been treated by a physician for any condition in the last twelve months? ❑ no ❑ yes
Doctor's name _____Condition? _____
When was your last physical exam? _____ Was your blood pressure normal? ❑ no ❑ yes
Was your cholesterol normal? ❑ no ❑ yes
List any surgeries with dates: _____
Describe past injuries or falls? _____
Have you been in any OTHER auto accidents? ❑ no ❑ yes=when? _____
Were you treated? ❑ no ❑ yes= by whom?_____Did you completely recover? ❑ no ❑ yes
Have you ever been treated by a chiropractor? ❑ no ❑ yes If yes, What area was treated? neck, mid back, low back . Did the adjustments relieve your symptoms? ❑ no ❑ yes
In general would you say your overall health right now is:
❑ Excellent ❑ Very good ❑ Good ❑ Fair ❑ Poor
Do you eat mostly healthy, nutritious food? ❑ no ❑ yes ❑ not sure **Do you eat breakfast?** ❑ no ❑yes
Do you smoke or chew tobacco? ❑ no ❑ yes=How many packs/cans a day? ____.
Do you drink alcohol? ❑ never ❑ yes=How many drinks a week?_____
Do you exercise? ❑ rarely ❑ occasionally ❑ regularly What type_____
Do you have a good supportive mattress? ❑ no ❑ yes
What is your favorite sleep position? ❑ side ❑ back ❑ stomach
Do you take vitamins? ❑ no ❑ yes=what?_____
Has your medical doctor advised you NOT to take certain vitamins? ❑ no ❑ yes
Have you had nutritional advise from: ❑ chiropractor ❑ naturopath ❑ health store ❑ medical doctor
(Women only)Are you pregnant? ❑ no ❑ **YES** How many pregnancies have you had? ___.
When was your last pap smear? _____ Was it normal? ❑ no ❑ yes
When was your last mammogram? _____Was it normal? ❑ no ❑ yes
(Men only) Have you had a prostate exam? ❑ no ❑ yes=when? _____.
Were the findings normal? ❑ no ❑ yes
Have you hired an attorney**?** ❑ no ❑ yes=whom? _____.
Signature _____