AUTO INJURY QUESTIONNAIRE

Please Print

Name_____ **Date**_____

Date of the accident_____ **Time of accident**_____ am/pm

Where were you in the vehicle? (please circle)

Drivers front seat Drivers side rear seat Passenger side front seat Right rear seat

Speed_____ **mph**

Make of vehicle_____ **Model**_____ **Year**_____

vehicle type (Please Circle)

compact car compact passenger truck full-size car mid-sized car
mini van motorcycle passenger truck

Accelerating? (Please Circle) YES or NO

What was your vehicle doing immediately prior to impact? (Please Circle)

Changing lanes
Continuing to drive unaware of the stopped vehicle ahead
Proceeding through the intersection disregarding the stop sign
Stopped for a stop sign
Turing left at an intersection
Other:_____
Continuing to drive unaware of red light
Proceeding through an intersection with the light
Slowing for traffic congestion
Stopped for a traffic light
Turing right at an intersection

What was your vehicles point of impact? (Please Circle)

Front bumper Left front fender Left rear fender Left side Rear bumper
Right front fender Right rear fender Right side Other:_____

Amount of damage to your vehicle $_____

Road condition (Please Circle)

Covered with gravel Covered with leaves or other debris Damp Dry
Icy Mostly dry with the first minutes of rain Muddy Sandy
Snow-covered Wet Other:_____

Visibility (Please Circle)

Excellent, with bright sunlight Excellent, with overcast light Reduced at dawn
Reduced at dusk Reduced at night Reduced due to fog
Reduced due to rain Reduced due to snow Other:_____

Was another vehicle involved? (Please Circle) YES or NO

Number of other vehicles _____

Which vehicle hit the other? (Please Circle)

More than one vehicle hit the patients vehicle
The patients vehicle hit by more than one vehicle
Other:_____
The other vehicle hit the patients vehicle
The patients vehicle hit the other vehicle

Was a police report filled out? (Please Circle) Yes or No

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PATIENT AT IMPACT

Air bags deployed (Please Circle) YES or NO

Did you lose consciousness after the injury? (Please Circle) YES or NO

Did you receive emergency care at the scene? (Please Circle) YES or NO

Position of headrest (Please Circle)

Adjusted high
Adjusted low
All the way down
All the way up
Improperly adjusted and offered negligible protection
Not equipped with headrest
Properly adjusted
Other:_____

Type(s) of seats restraint(s), you were wearing if any (Please Circle)

A shoulder harness connected to the door
A shoulder harness only
Lap belts only
No seatbelts
Seatbelts with shoulder harness
Other:_____

Where did you go immediately after the accident? (Please Circle)

Home
A walk-in emergency clinic
To continued with scheduled plans
To the hospital emergency room
To the hospital ER by ambulance
To work
Other:_____

Were you prepared for the impact? (Please Circle) YES or NO

Drivers foot on brake at time of impact? (Please Circle) YES or NO

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

Down
Down and to the right
Down and to the left
Level and to the left
Level and to the right
Straight ahead
Up
Other:_____

OTHER VEHICLE

Other vehicle type (Please Circle)

compact car
compact passenger truck
full-size car
mid-sized car
mini van
motorcycle
passenger truck

Make of vehicle_____ **Model**_____ **Year**_____

Accelerating? (Please Circle) YES or NO

What was the other vehicle doing immediately prior to impact? (Please Circle)

Changing lanes
Continuing to drive unaware of red light
Continuing to drive unaware of the stopped vehicle ahead
Proceeding through an intersection with the light
Proceeding through the intersection disregarding the stop sign
Slowing for traffic congestion
Stopped for a stop sign
Stopped for a traffic light
Turing left at an intersection
Turing right at an intersection
Other:_____

What was the other vehicles point of impact? (Please Circle)

Front bumper
Left front fender
Left rear fender
Left side
Rear bumper
Right front fender
Right rear fender
Right side
Other:_____

Amount of damage to the other vehicle **$**_____

CIRCLE THE SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT:

Headaches	Neck Pain	Sleeping Problems	Loss of Concentration
Chest Pain	Dizziness	Mid-Back Pain	Foggy Thoughts
Depression	Ears Ring	Low Back Pain	Sensitive to Motion
Jaw Pain or Click	Stomach Upset	Nervousness	Light Sensitivity
Pain Shoots Down Legs	Neck Stiffness	Fatigue	Pins and Needles in Legs
Pain Shoots Down Arms	Pins & Needles in Arms	Loss of Coordination	Other:
Blurry Vision			

Name of hospital & location_____
Were you admitted? (Please Circle) YES or NO **For how long?**_____
Emergency room only? (Please Circle) YES or NO

Treatment received_____

Was any other doctor consulted after your accident? (Please Circle) YES or NO

If so, what was the doctor's name?_____ **(Please Circle)** DC MD DO DDS
What was the diagnosis?_____
What treatment was given?_____
How often did you see the doctor?_____
Have you ever had any complaints in the involved area before? (Please Circle) YES or NO
If so, what were the complaints?_____
Before the injury, were you capable of working on an equal basis with others your age?(Please Circle)
YES or NO
Are your work activities restricted as a result of this accident? (Pleas Circle) YES or NO
Have you lost any days of work?(Please Circle) YES or NO
Dates_____

Were you struck from __behind __right side ___left side ___front ___auto parked

You were heading___North___East___South ___West on_____**(street or hwy)**

Other vehicle was headed___North___East___South___West on_____**(street or hwy)**

Were there any witnesses?(Pleas Circle) YES or NO
Names_____
Have you made settlement with the insurance company in any way? ___yes___no

Did you have any physical complaints BEFORE THE ACCIDENT? ___yes___no
Please Describe_____
Have you ever been involved in an accident before?___yes___no
If yes, please describe, including date(s) and type(s) of accidents, as well as injury(ies) received:_____
_____
_____
_____

Insurance companies involved_____
Have you been contacted by an insurance adjuster or representative regarding this claim?__yes___no

Your auto insurance company at the time of the accident?_____

Policy#_____**Were you given a claim#**_____yes_____no

Claim#_____**Adjuster's name handling your File**_____
Driver of vehicle in which you were injured (if applicable)

Name_____ **Insurance Company**_____
Policy #_____

Patient Signature_____ **Date**_____