Alliance Chiropractic and Massage

Automobile Accident Questionnaire

Patient Name: _____

Date of Accident: _____ Date: _____

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

Your position in the vehicle:

Front Seat: ▫ Driver ▫ Middle ▫ Right
Back/Second Seat: ▫ Left ▫ Middle ▫ Right
Third Seat: ▫ Left ▫ Middle ▫ Right

Vehicle Type:

▫ Motorcycle ▫ Car ▫ Pickup ▫ SUV ▫ Van ▫ Bus ▫ Other: _____

Vehicle Size:

▫ Compact ▫ Mid-Size ▫ Full-Size ▫ Other: _____

Speed of your vehicle:

▫ Stopped ▫ Parked ▫ Slowing ▫ Moving Slowly ▫ Moving Moderately
▫ Moving Fast ▫ Moving at approximately _____ mph

Why vehicle was slowed or stopped:

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

Collision Type:

▫ Driver Side Impact ▫ Passenger Side Impact ▫ Head on Collision
▫ Front Impact ▫ Rear Impact ▫ Pedestrian Incident

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

Vehicle Type:

▫ Motorcycle ▫ Car ▫ Pickup ▫ SUV ▫ Van ▫ Bus ▫ Other: _____

Vehicle Size:

▫ Compact ▫ Mid-Size ▫ Full-Size ▫ Other: _____

3 *CONDITIONS AT THE TIME OF THE ACCIDENT:*

Time of Day:

▫ Daylight ▫ 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 ▫ Fog ▫ Snow ▫ Traffic

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4 *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 the impact ▫ Not the driver

Did the air bag deploy?

▫ Yes ▫ No ▫ Car not equipped with air bag

What position was YOUR headrest in?

▫ High position ▫ Middle position ▫ Low position

Position of YOUR head at the time of impact?

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

Position of YOUR body at the time of impact?

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

Damage to the vehicle YOU were in:

▫ Incurred minimal damage ▫ Incurred moderate damage ▫ Incurred severe damage ▫ Was totaled
▫ Amount of damage: $_____ ▫ Not known

Citations:

▫ None issued ▫ Driver of other vehicle ▫ Yourself ▫ Not sure

5 *AS A RESULT OF THE FORCE OF THE COLLISION, WHICH PART(S) OF YOUR BODY STRUCK THE VEHICLE?*

▫ Head ▫ Left Arm ▫ Right Arm ▫ Torso ▫ Left Leg
▫ Right Leg

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

Did you lose consciousness?

▫ Yes ▫ No

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

▫ Disoriented ▫ Dizzy ▫ Dazed ▫ Weak ▫ Nervous
▫ Nauseated

Were you able to walk unaided?

▫ Yes ▫ No

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Where did you go…?

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

Next day discomfort…?

▫ Increased ▫ Decreased ▫ Same

Did your major complaints exist before the accident?

▫ Yes ▫ No

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)?

▫ 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						

At the hospital what treatment did you receive?

_____
_____
_____

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Did they prescribe you any medication? ▫ No ▫ Yes (If yes, what?)
_____
_____
_____

What medications are you CURRENTLY taking for your motor vehicle crash injuries?
_____
_____
_____