



AUTO ACCIDENT QUESTIONNAIRE

Name _____ Date of Accident ____/____/____ Brief description of accident _____

Patient's vehicle (yr., make, model) _____ Estimated speed at impact _____ MPH

Patient's vehicle hit by _____ Estimated speed at impact _____ MPH

Time: Day Night Dawn Dusk Road Conditions: Dry Damp Wet Icy Snow Covered

Did vehicle have seatbelts? No Yes Were seatbelts worn? No Yes Shoulder Lap

List your seat position in vehicle: Driver Front Passenger Rear Drivers Side Middle Back Rear Passenger

If vehicle had headrests, describe the position compared with top of your head: Top of headrest aligned with top of head

Top of headrest aligned with middle of head Top of headrest aligned with bottom

Briefly describe the impact collision: Head on Collision Left Side Impact Right Side Impact Rear End Collision

List any parts of your body that made contact with vehicle parts _____

Hands: One on Wheel Two on Wheel Were you braced for the impact? Yes No Were Brakes applied? Yes No

Were you looking up into inside rear view mirror? Yes No Was your car stopped? Yes No

Were you looking at outside door mirror? Yes No Loss of consciousness? Yes No

Wearing glasses? Yes No Still on? Yes No Wearing hat? Yes No Still on? Yes No

Wearing dentures? Yes No Still in? Yes No

Estimated property damage: Totaled Drivable Not Drivable

Others in car: # _____ Injured: Yes No Police on Scene? Yes No Report made: Yes No

Initial Symptoms: None Headache Dizzy Disoriented Neck pain/stiff Nausea Vomiting
 Blurred Vision Ringing in ears Shock Mid back pain/stiff Low back pain/stiff Numbness / Tingling

1st symptom appeared _____hr(s) after MVA. Did you go to the hospital? Yes No Name: _____

When did you go to the hospital? Immediately Later, when _____

If yes, how did you get to the hospital? Ambulance Other _____ If admitted, how long did you stay? _____

At hospital: X-ray Lab Rx Meds/Muscle Relaxants Cervical Collar Follow Up instructions

Any medication prescribed? Yes No List name _____

Any previous motor vehicle accidents? Yes No Describe: _____

If yes, was treatment rendered previously? Yes No Describe: _____

Patient Signature _____ DOB: ____/____/____ Date ____/____/____