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 ______/______/______

Dr. / Staff Initial _____ _____