AUTOMOBILE COLLISION QUESTIONNAIRE

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

THE BELOW INFORMATION PERTAINS TO THE ABOVE NOTED COLLISION

Doctors, Therapist or Hospitals have you visited since the collision:
❑Doctor Name/Dates: _____
❑Hospital Name/Dates: _____
❑Therapist Name/Dates: _____
❑None

Medications or Supplements you've been taking for the injuries/conditions from collision:
❑Prescribed Medications: _____
❑Over The Counter Medications: _____
❑Supplements or Herbs: _____
❑None

Therapies, Tests or other things you have done or are doing for the injuries from collision:
❑Therapies (PT, etc): _____
❑Diagnostic Test (Films, etc): _____
❑Other: _____
❑None

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

Your Vehicle type:
❑Car ❑Pickup
❑Van ❑Truck
❑Station Wagon ❑Bus
❑Other_____

Your Vehicle size:
❑Subcompact ❑Full-size
❑Compact ❑Mini
❑Mid-size ❑Light
❑Heavy
❑Other_____

Your position in the vehicle:
❑Driver
❑Passenger -------- Location-----→ ❑Left ❑Middle ❑Right
❑Other _____ ❑Front Passenger ❑Rear Passenger ❑Third Seat (rear)

Speed of your vehicle:
❑Stopped ❑Moving moderately
❑Parked ❑Moving Fast
❑Slowing ❑Moving at approx ____MPH
❑Moving slowly

Why Vehicle was slowed or stopped:
❑Traffic Signal ❑Parking
❑Pedestrian ❑Traffic
❑Stop Sign ❑Busy Intersection

Collision Type:
❑Driver Side Impact ❑Head On Collision
❑Passenger Side Impact ❑Rear Impact
❑Front Impact ❑Pedestrian Incident

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

Their Vehicle type:

❑Car ❑Pickup
❑Van ❑Truck
❑Station Wagon ❑Bus
❑Other_____

Their Vehicle size:

❑Subcompact ❑Full-size
❑Compact ❑Mini
❑Mid-size ❑Light
❑Heavy
❑Other_____

CONDITIONS AT THE TIME OF THE COLLISON:

Time of day:

❑Full 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
❑Snow
❑Fog
❑Traffic

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

Were you...

❑Totally **un**aware that the collision was impending
❑Aware that the collision was impending
❑Aware that the collision 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 ❑Middle position
❑ Low position

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
❑Across the vehicle
❑Outside the vehicle ❑Under the vehicle

Damage to vehicle YOU were in:

❑Incurred minimal damage
❑Incurred moderate damage
❑Incurred severe damage
❑Was totaled
❑Not known

Citations Issued:

❑None issued
❑Issued to you
❑To the Driver of vehicle patient was a passenger of
❑To the Driver of other vehicle
❑Not sure

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

Head/Jaw

❑Steering wheel ❑Right door
❑Dashboard ❑Left window
❑Windshield ❑Right window
❑Armrest ❑Console
❑Headrest ❑Gear shift
❑Rear view mirror ❑Front seat
❑Left door ❑Backseat

Left Arm

❑Steering wheel ❑Right door
❑Dashboard ❑Left window
❑Windshield ❑Right window
❑Armrest ❑Console
❑Headrest ❑Gear shift
❑Rear view mirror ❑Front seat
❑Left door ❑Backseat

Right Arm

❑Steering wheel ❑Right door
❑Dashboard ❑Left window
❑Windshield ❑Right window
❑Armrest ❑Console
❑Headrest ❑Gear shift
❑Rear view mirror ❑Front seat
❑Left door ❑Backseat

Torso

❑Steering wheel ❑Right door
❑Dashboard ❑Left window
❑Windshield ❑Right window
❑Armrest ❑Console
❑Headrest ❑Gear shift
❑Rear view mirror ❑Front seat
❑Left door ❑Backseat

Left Leg

❑Steering wheel ❑Right door
❑Dashboard ❑Left window
❑Windshield ❑Right window
❑Armrest ❑Console
❑Headrest ❑Gear shift
❑Rear view mirror ❑Front seat
❑Left door ❑Backseat

Right Leg

❑Steering wheel ❑Right door
❑Dashboard ❑Left window
❑Windshield ❑Right window
❑Armrest ❑Console
❑Headrest ❑Gear shift
❑Rear view mirror ❑Front seat
❑Left door ❑Backseat

THE FOLLOWING QUESTIONS CONCERN THE TIME IMMEDIATELY FOLLOWING THE COLLISON:

Did you lose consciousness?

❑Yes
❑No

Immediately following the collision, 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

Did your major complaints exist before the collision?

❑Did Exist ❑ Did Not Exist

What areas did you IMMEDIATELY feel pain?

❑Jaw	❑Left	❑Right
❑Head	❑Left	❑Right
❑Neck	❑Left	❑Right
❑Upper back	❑Left	❑Right
❑Mid back	❑Left	❑Right
❑Ribs	❑Left	❑Right
❑Chest	❑Left	❑Right
❑Abdomen	❑Left	❑Right
❑Low Back	❑Left	❑Right
❑Pelvis	❑Left	❑Right

UPPER BODY REGION

❑ Shoulder	❑Left	❑Right
❑ Arm	❑Left	❑Right
❑ Elbow	❑Left	❑Right
❑ Wrist	❑Left	❑Right
❑ Hand	❑Left	❑Right
❑ Fingers	❑Left	❑Right
❑ Buttock	❑Left	❑Right

LOWER BODY REGION

Hip	❑Left	❑Right
Thigh	❑Left	❑Right
Knee	❑Left	❑Right
Calf	❑Left	❑Right
Ankle	❑Left	❑Right
Foot	❑Left	❑Right
Toes	❑Left	❑Right

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What areas did you experience cuts?

❑Jaw ❑Left ❑Right
❑Head ❑Left ❑Right
❑Neck ❑Left ❑Right
❑Upper back ❑Left ❑Right
❑Mid back ❑Left ❑Right
❑Ribs ❑Left ❑Right
❑Chest ❑Left ❑Right
❑Abdomen ❑Left ❑Right
❑Low Back ❑Left ❑Right
❑Pelvis ❑Left ❑Right

UPPER BODY REGION

❑ Shoulder ❑Left ❑Right
❑ Arm ❑Left ❑Right
❑ Elbow ❑Left ❑Right
❑ Wrist ❑Left ❑Right
❑ Hand ❑Left ❑Right
❑ Fingers ❑Left ❑Right
❑ Buttock ❑Left ❑Right

LOWER BODY REGION

Hip ❑Left ❑Right
Thigh ❑Left ❑Right
Knee ❑Left ❑Right
Calf ❑Left ❑Right
Ankle ❑Left ❑Right
Foot ❑Left ❑Right
Toes ❑Left ❑Right

At the hospital, what areas were x-rayed?

❑Jaw ❑Left ❑Right
❑Head ❑Left ❑Right
❑Neck ❑Left ❑Right
❑Upper back ❑Left ❑Right
❑Mid back ❑Left ❑Right
❑Ribs ❑Left ❑Right
❑Chest ❑Left ❑Right
❑Abdomen ❑Left ❑Right
❑Low Back ❑Left ❑Right
❑Pelvis ❑Left ❑Right

UPPER BODY REGION

❑ Shoulder ❑Left ❑Right
❑ Arm ❑Left ❑Right
❑ Elbow ❑Left ❑Right
❑ Wrist ❑Left ❑Right
❑ Hand ❑Left ❑Right
❑ Fingers ❑Left ❑Right
❑ Buttock ❑Left ❑Right

LOWER BODY REGION

Hip ❑Left ❑Right
Thigh ❑Left ❑Right
Knee ❑Left ❑Right
Calf ❑Left ❑Right
Ankle ❑Left ❑Right
Foot ❑Left ❑Right
Toes ❑Left ❑Right

Areas of pain on the following day?

❑increased ❑decreased ❑same

UPPER BODY REGION

❑Jaw ❑Left ❑Right
❑Head ❑Left ❑Right
❑Neck ❑Left ❑Right
❑Upper back ❑Left ❑Right
❑Mid back ❑Left ❑Right
❑Ribs ❑Left ❑Right
❑Chest ❑Left ❑Right
❑Abdomen ❑Left ❑Right
❑Low Back ❑Left ❑Right
❑Pelvis ❑Left ❑Right

❑ Shoulder ❑Left ❑Right
❑ Arm ❑Left ❑Right
❑ Elbow ❑Left ❑Right
❑ Wrist ❑Left ❑Right
❑ Hand ❑Left ❑Right
❑ Fingers ❑Left ❑Right
❑ Buttock ❑Left ❑Right

LOWER BODY REGION

Hip ❑Left ❑Right
Thigh ❑Left ❑Right
Knee ❑Left ❑Right
Calf ❑Left ❑Right
Ankle ❑Left ❑Right
Foot ❑Left ❑Right
Toes ❑Left ❑Right

❑Only the same areas hurt the next day.
❑Do not remember.
❑Does not apply since today is the same day of the collision.

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Areas of pain 2 days afterwards?

❑increased ❑decreased ❑same

			UPPER BODY REGION			LOWER BODY REGION		
❑Jaw	❑Left	❑Right						
❑Head	❑Left	❑Right	❑ Shoulder	❑Left	❑Right	Hip	❑Left	❑Right
❑Neck	❑Left	❑Right	❑ Arm	❑Left	❑Right	Thigh	❑Left	❑Right
❑Upper back	❑Left	❑Right	❑ Elbow	❑Left	❑Right	Knee	❑Left	❑Right
❑Mid back	❑Left	❑Right	❑ Wrist	❑Left	❑Right	Calf	❑Left	❑Right
❑Ribs	❑Left	❑Right	❑ Hand	❑Left	❑Right	Ankle	❑Left	❑Right
❑Chest	❑Left	❑Right	❑ Fingers	❑Left	❑Right	Foot	❑Left	❑Right
❑Abdomen	❑Left	❑Right	❑ Buttock	❑Left	❑Right	Toes	❑Left	❑Right
❑Low Back	❑Left	❑Right						
❑Pelvis	❑Left	❑Right						

❑Only the same areas hurt 2 days afterwards.
❑Do not remember.
❑Does not apply since today is the day after the collision.

Areas of pain 3 days afterwards?

❑increased ❑decreased ❑same

			UPPER BODY REGION			LOWER BODY REGION		
❑Jaw	❑Left	❑Right						
❑Head	❑Left	❑Right	❑ Shoulder	❑Left	❑Right	Hip	❑Left	❑Right
❑Neck	❑Left	❑Right	❑ Arm	❑Left	❑Right	Thigh	❑Left	❑Right
❑Upper back	❑Left	❑Right	❑ Elbow	❑Left	❑Right	Knee	❑Left	❑Right
❑Mid back	❑Left	❑Right	❑ Wrist	❑Left	❑Right	Calf	❑Left	❑Right
❑Ribs	❑Left	❑Right	❑ Hand	❑Left	❑Right	Ankle	❑Left	❑Right
❑Chest	❑Left	❑Right	❑ Fingers	❑Left	❑Right	Foot	❑Left	❑Right
❑Abdomen	❑Left	❑Right	❑ Buttock	❑Left	❑Right	Toes	❑Left	❑Right
❑Low Back	❑Left	❑Right						
❑Pelvis	❑Left	❑Right						

❑Only the same areas hurt 3 days afterwards.
❑Do not remember.
❑Does not apply since today is the second day after the collision.

(Please note: All information in this and other patient forms are kept private and confidential according to the 2003 HIPPA guidelines.)

Patient's Signature: _____ **Date:** _____

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