Automobile Accident Questionnaire

Name_____ Birth Date_____
Today's Date_____ Date of Injury_____State of Injury_____

1. Were you the driver or passenger?_____
2. Where were you seated in the car?_____
3. Were you using the seat belt? Y N Was it equipped with a shoulder harness?_____
4. Was the head restraint (headrest) adjusted? Y N_____
5. What was the seat position (upright at 90 degrees or inclined)?_____
6. What was the mechanism of injury (rear impact, side impact, front impact)?_____
7. Was there a secondary impact (another car, a curb or barrier, etc.)?_____
8. Were you prepared for the impact? Y N_____
9. Which direction was your head or body turned at the time of impact?_____
10. If you were wearing glasses or a hat where were they after the impact?_____
11. Did you strike any part of your body on the interior of the car? (What and Where) ___

12. Did you loose consciousness? How long? Y N_____
13. Were you attended to by a EMT? Y N_____
14. Were you taken to the hospital? Y N Which Hospital?_____
    IF YES: By ambulance or other transportation?_____
    Were you x-rayed? Y N What body areas?_____
    Were you admitted over night? Y N_____
    Were you given orthopedic supports or braces? Y N_____
    Were you given medications or prescriptions Y N What type?_____
    What were your discharge instructions? (No work, rest, home care,follow-up, exercise etc.)_____
14. Have you had any other medical care since the injury? Y N
    Doctor or clinic name _____
    When consulted_____
    Treatment:_____
    Doctor or clinic name _____
    When consulted_____
    Treatment:_____
15. Have you had any diagnostic tests since the accident? (MRI, CT Scan, Bone Scan, X-Ray etc)
16. Have you tried any home treatments? (Hot packs, Medications, Massage Etc)? Were they effective?_____
17. Have you had any previous accident or injuries? Y N When_____

18. Have you missed work? Y N TTD from _____ to _____ PPD from _____ to

Patient Signature_____ Date_____