

AUTOMOBILE ACCIDENT QUESTIONNAIRE

Circle one

Patient's Name: _____ Today's Date: _____
What What
Date of Accident: _____ City _____ Parish _____

Police **City Police**
Report: **State Trooper**
Parish Police

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

The police gave the driver an incident #
Please write it here

Vehicle type:

- Car Pickup
 Van Truck
 Station Wagon
 Other _____

Vehicle size:

- Subcompact Full-size
 Compact Mini
 Bus Mid-size Light
 Heavy Other _____

Your position in the vehicle:

- Driver Passenger Front Passenger Rear Passenger Third Seat (rear)

Speed of your vehicle:

- Stopped Moving Moderately
 Parked Moving Fast
 Slowing Moving at apprx _____MPH

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

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

Vehicle type:

- Car Pickup
 Van Truck
 Station Wagon
 Other _____

Vehicle size:

- Subcompact Full-size
 Compact Mini
 Bus Mid-size Light
 Heavy Other _____

CONDITIONS AT THE TIME OF THE ACCIDENT:

Time of day:

- Full daylight
 Dawn
 Dusk
 Night
 Ice covered

Road Conditions:

- Dry
 Damp
 Wet
 Snow covered
 Patchy Ice/Snow

Visibility:

- Excellent
 Good
 Fair
 Poor

Visibility compromised by:

- Brightness
 Darkness
 Rain
 Fog
 Traffic

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

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

Position of Your body at time of impact?

- Straight
- Tilted forward
- Rotated to the left
- Rotated to the right

Damage to vehicle YOU were in:

- Incurred minimal damage
- Incurred moderate damage
- Incurred severe damage
- Was totalled
- Not known

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

Was your body thrown...?

- Backward and then forward Across the vehicle
- Forward then backward
- To the left To the left then the right
- To the right To the right, then the left
- Outside the vehicle Under the vehicle

Citations: (Police gave ticket to:)

- None issued
- Yourself
- Driver of vehicle patient was a passenger of
- Driver of other vehicle
- Not sure

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

Head

- | | |
|---|---------------------------------------|
| <input type="checkbox"/> Steering wheel | <input type="checkbox"/> Right door |
| <input type="checkbox"/> Dashboard | <input type="checkbox"/> Left window |
| <input type="checkbox"/> Windshield | <input type="checkbox"/> Right window |
| <input type="checkbox"/> Armrest | <input type="checkbox"/> Console |
| <input type="checkbox"/> Headrest | <input type="checkbox"/> Gear shift |
| <input type="checkbox"/> Rear view mirror | <input type="checkbox"/> Front seat |
| <input type="checkbox"/> Left door | <input type="checkbox"/> Backseat |

Left Arm

- | | |
|---|---------------------------------------|
| <input type="checkbox"/> Steering wheel | <input type="checkbox"/> Right door |
| <input type="checkbox"/> Dashboard | <input type="checkbox"/> Left window |
| <input type="checkbox"/> Windshield | <input type="checkbox"/> Right window |
| <input type="checkbox"/> Armrest | <input type="checkbox"/> Console |
| <input type="checkbox"/> Headrest | <input type="checkbox"/> Gear shift |
| <input type="checkbox"/> Rear view mirror | <input type="checkbox"/> Front seat |
| <input type="checkbox"/> Left door | <input type="checkbox"/> Backseat |

Right Arm

- | | |
|---|---------------------------------------|
| <input type="checkbox"/> Steering wheel | <input type="checkbox"/> Right door |
| <input type="checkbox"/> Dashboard | <input type="checkbox"/> Left window |
| <input type="checkbox"/> Windshield | <input type="checkbox"/> Right window |
| <input type="checkbox"/> Armrest | <input type="checkbox"/> Console |
| <input type="checkbox"/> Headrest | <input type="checkbox"/> Gear shift |
| <input type="checkbox"/> Rear view mirror | <input type="checkbox"/> Front seat |
| <input type="checkbox"/> Left door | <input type="checkbox"/> Backseat |

Torso

- | | |
|---|---------------------------------------|
| <input type="checkbox"/> Steering wheel | <input type="checkbox"/> Right door |
| <input type="checkbox"/> Dashboard | <input type="checkbox"/> Left window |
| <input type="checkbox"/> Windshield | <input type="checkbox"/> Right window |
| <input type="checkbox"/> Armrest | <input type="checkbox"/> Console |
| <input type="checkbox"/> Headrest | <input type="checkbox"/> Gear shift |
| <input type="checkbox"/> Rear view mirror | <input type="checkbox"/> Front seat |
| <input type="checkbox"/> Left door | <input type="checkbox"/> Backseat |

Left Leg

- | | |
|---|---------------------------------------|
| <input type="checkbox"/> Steering wheel | <input type="checkbox"/> Right door |
| <input type="checkbox"/> Dashboard | <input type="checkbox"/> Left window |
| <input type="checkbox"/> Windshield | <input type="checkbox"/> Right window |
| <input type="checkbox"/> Armrest | <input type="checkbox"/> Console |
| <input type="checkbox"/> Headrest | <input type="checkbox"/> Gear shift |
| <input type="checkbox"/> Rear view mirror | <input type="checkbox"/> Front seat |
| <input type="checkbox"/> Left door | <input type="checkbox"/> Backseat |

Right Leg

- | | |
|---|---------------------------------------|
| <input type="checkbox"/> Steering wheel | <input type="checkbox"/> Right door |
| <input type="checkbox"/> Dashboard | <input type="checkbox"/> Left window |
| <input type="checkbox"/> Windshield | <input type="checkbox"/> Right window |
| <input type="checkbox"/> Armrest | <input type="checkbox"/> Console |
| <input type="checkbox"/> Headrest | <input type="checkbox"/> Gear shift |
| <input type="checkbox"/> Rear view mirror | <input type="checkbox"/> Front seat |
| <input type="checkbox"/> Left door | <input type="checkbox"/> Backseat |

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

Did you lose consciousness?

- Yes
 No

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

- Dizzy Weak Dazed
 Nervous Disoriented Nauseated

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

Next day discomfort...?

- increased decreased same

Did your major complaints exist before the accident?

- Yes No

In what areas did you IMMEDIATELY feel pain?

- | | | | | | | | |
|-------------------------------------|----------|-------------------------------|--------------------------------|-------|-------------------------------|--------------------------------|-----------------------------------|
| <input type="checkbox"/> Head | Shoulder | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Hip | <input type="checkbox"/> Left | <input type="checkbox"/> Right | <input type="checkbox"/> Low Back |
| <input type="checkbox"/> Neck | Arm | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Thigh | <input type="checkbox"/> Left | <input type="checkbox"/> Right | <input type="checkbox"/> Pelvis |
| <input type="checkbox"/> Upper back | Elbow | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Knee | <input type="checkbox"/> Left | <input type="checkbox"/> Right | |
| <input type="checkbox"/> Mid back | Wrist | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Calf | <input type="checkbox"/> Left | <input type="checkbox"/> Right | |
| <input type="checkbox"/> Ribs | Hand | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Ankle | <input type="checkbox"/> Left | <input type="checkbox"/> Right | |
| <input type="checkbox"/> Chest | Fingers | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Foot | <input type="checkbox"/> Left | <input type="checkbox"/> Right | |
| <input type="checkbox"/> Abdomen | Buttock | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Toes | <input type="checkbox"/> Left | <input type="checkbox"/> Right | |

In what areas did you experience lacerations (cuts)?

- | | | | | | | | |
|-------------------------------------|----------|-------------------------------|--------------------------------|-------|-------------------------------|--------------------------------|-----------------------------------|
| <input type="checkbox"/> Head | Shoulder | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Hip | <input type="checkbox"/> Left | <input type="checkbox"/> Right | <input type="checkbox"/> Low Back |
| <input type="checkbox"/> Neck | Arm | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Thigh | <input type="checkbox"/> Left | <input type="checkbox"/> Right | <input type="checkbox"/> Pelvis |
| <input type="checkbox"/> Upper back | Elbow | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Knee | <input type="checkbox"/> Left | <input type="checkbox"/> Right | |
| <input type="checkbox"/> Mid back | Wrist | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Calf | <input type="checkbox"/> Left | <input type="checkbox"/> Right | |
| <input type="checkbox"/> Ribs | Hand | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Ankle | <input type="checkbox"/> Left | <input type="checkbox"/> Right | |
| <input type="checkbox"/> Chest | Fingers | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Foot | <input type="checkbox"/> Left | <input type="checkbox"/> Right | |
| <input type="checkbox"/> Abdomen | Buttock | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Toes | <input type="checkbox"/> Left | <input type="checkbox"/> Right | |

At the hospital, what areas were x-rayed?

- | | | | | | | | |
|-------------------------------------|----------|-------------------------------|--------------------------------|-------|-------------------------------|--------------------------------|-----------------------------------|
| <input type="checkbox"/> Head | Shoulder | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Hip | <input type="checkbox"/> Left | <input type="checkbox"/> Right | <input type="checkbox"/> Low Back |
| <input type="checkbox"/> Neck | Arm | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Thigh | <input type="checkbox"/> Left | <input type="checkbox"/> Right | <input type="checkbox"/> Pelvis |
| <input type="checkbox"/> Upper back | Elbow | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Knee | <input type="checkbox"/> Left | <input type="checkbox"/> Right | |
| <input type="checkbox"/> Mid back | Wrist | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Calf | <input type="checkbox"/> Left | <input type="checkbox"/> Right | |
| <input type="checkbox"/> Ribs | Hand | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Ankle | <input type="checkbox"/> Left | <input type="checkbox"/> Right | |
| <input type="checkbox"/> Chest | Fingers | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Foot | <input type="checkbox"/> Left | <input type="checkbox"/> Right | |
| <input type="checkbox"/> Abdomen | Buttock | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Toes | <input type="checkbox"/> Left | <input type="checkbox"/> Right | |

Where did you experience pain on the day FOLLOWING the accident?

- | | | | | | | | |
|-------------------------------------|----------|-------------------------------|--------------------------------|-------|-------------------------------|--------------------------------|-----------------------------------|
| <input type="checkbox"/> Head | Shoulder | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Hip | <input type="checkbox"/> Left | <input type="checkbox"/> Right | <input type="checkbox"/> Low Back |
| <input type="checkbox"/> Neck | Arm | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Thigh | <input type="checkbox"/> Left | <input type="checkbox"/> Right | <input type="checkbox"/> Pelvis |
| <input type="checkbox"/> Upper back | Elbow | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Knee | <input type="checkbox"/> Left | <input type="checkbox"/> Right | |

<input type="checkbox"/> Mid back	Wrist	<input type="checkbox"/> Left	<input type="checkbox"/> Right	Calf	<input type="checkbox"/> Left	<input type="checkbox"/> Right
<input type="checkbox"/> Ribs	Hand	<input type="checkbox"/> Left	<input type="checkbox"/> Right	Ankle	<input type="checkbox"/> Left	<input type="checkbox"/> Right
<input type="checkbox"/> Chest	Fingers	<input type="checkbox"/> Left	<input type="checkbox"/> Right	Foot	<input type="checkbox"/> Left	<input type="checkbox"/> Right
<input type="checkbox"/> Abdomen	Buttock	<input type="checkbox"/> Left	<input type="checkbox"/> Right	Toes	<input type="checkbox"/> Left	<input type="checkbox"/> Right

Patient's Signature: _____