

# Advanced Healthcare

## *Automobile Accident Questionnaire*

**Date and time of accident:**        /        /        @        :        am        pm

1. **Your location in the vehicle?**        Driver        Front Passenger        Rear Passenger ( right   left )

2. **Type of vehicle you were in?** \_\_\_\_\_

3. **If other vehicles were involved, describe how the vehicles collided with your vehicle:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. **What was your vehicle doing at the moment of impact?**

Stopped        Moving slow(1-15mph)        Moving moderately(16-35mph)        Moving fast(>35mph)

5. **What was the extent of the damage to your car?**        Mild        Moderate        Severe

6. **Were traffic citations issued?**    Y    N    Unsure        **If yes, to whom:**    Me    Other driver

7. **Were you prepared for the accident (did you brace?)**    Y    N

8. **What was your body position at impact?**    Forward    Turned left    Turned right    Unsure

9. **What was your head position at impact?**    Forward    Turned left    Turned right    Unsure

10. **What object(s) did your head hit at impact?**

Headrest    Steering wheel    Windshield    Nothing    Unsure    Other: \_\_\_\_\_

11. **What object(s) did your body hit at impact?**

Steering wheel    Console    Side door    Nothing    Unsure    Other: \_\_\_\_\_

12. **Did you lose consciousness?**    Y    N    **For how long?** \_\_\_\_\_

13. **Were you wearing a seat belt?**    Y    N        **Did your air bags deploy?**    Y    N

14. **How did you feel following the accident?**    Nervous    Dazed    Confused    Angry    Normal

15. **Cuts or fractures?**    Y    N    **Location:** \_\_\_\_\_

16. **When did you develop pain?**    Immediately    Hours later    Days later    Weeks later

17. **Did you receive emergency care at the accident scene?**    Y    N    **Describe:** \_\_\_\_\_

18. **Where did you go following the accident?**    Home    Work    Hospital    Other: \_\_\_\_\_

19. **If you went to the hospital, what date did you go?**    /    /    @    :    am    pm

20. **Name of the hospital:** \_\_\_\_\_ **Doctor's name** \_\_\_\_\_

21. **During hospital visit, I received:**    Examination    X-rays    MRI    CT scan

22. **Were medications prescribed?**    Y    N    **What?**    Anti-inflammatories    Muscle relaxant    Pain meds

23. **Did you seek medical attention elsewhere before consulting this office?**    Y    N

**If yes, with whom?** \_\_\_\_\_ **Specialty:** \_\_\_\_\_