AUTO COLLISION QUESTIONNAIRE I

Patient_____Date_____

Please explain in detail how your accident happened: _____

_____

_____

_____

_____

_____

_____

State auto collision occurred in: ☐ WV ☐ OH Other_____

Driver of vehicle you were injured in: ☐ Self _____

Name of person/adjustor who has contacted you:_____

Driver of vehicle that hit you: ☐ None _____

Name of person/adjustor who has contacted you:_____

Have you retained an attorney? ☐ No ☐ Yes ☐ Not Yet

If so, name, address & phone_____

Date and time of accident:_____ ☐ am ☐ pm # of people in your vehicle:_____

Were you the: ☐ Driver ☐ Front Passenger ☐ Rear Passenger Other_____

Were the police notified? ☐ Yes ☐ No Was there a police report filed? ☐ Yes ☐ No

Did your vehicle strike another vehicle involved? ☐ Yes ☐ No Other_____

Did other vehicle(s) strike your vehicle? ☐ Yes ☐ No Other_____

Impact to your vehicle was on: ☐ Front ☐ Rear ☐ Driver Side ☐ Passenger Side ☐ Rooftop

☐ Front Right corner ☐ Front Left corner ☐ Rear Right corner ☐ Rear Left Corner

Compared to my vehicle, the other vehicle was: ☐ Bigger ☐ Smaller ☐ Same size

The collision moved my vehicle: ☐ A little ☐ More than a little ☐ A lot

The amount of damage to my vehicle was: ☐ A little ☐ More than a little ☐ A lot

Road conditions were: ☐ Dry ☐ Wet ☐ Ice/snow ☐ Dirt ☐ Gravel ☐ Other_____

Did airbag employ? ☐ Yes ☐ No Were you injured by the airbag? ☐ Yes ☐ No

Did head strike windshield or object? ☐ Yes ☐ No Were you knocked unconscious? ☐ No ☐ Yes, how long _____

Direction you were looking when accident occurred? ☐ Straight ahead ☐ Down ☐ Up ☐ Turned Right ☐ Turned Left

Other_____

Top of headrest was located… ☐ Above ☐ Center ☐ Below ☐ Unknown … to top of your head.

The distance between my head & the headrest was: ☐ less than 1 inch ☐ 1-2 inches ☐ greater than 2 inches ☐ Unknown

My seat was: ☐ Not tilted back ☐ Tilted back a little ☐ Tilted back more than a little

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Type of restraints used? ☐ Shoulder & lap ☐ Lap only ☐ None used

Were bruises or injuries received as a result of the seat belt? ☐ Yes ☐ No

Location: ☐ Stomach ☐ Breast ☐ Shoulder Other_____

Were you surprised by the accident? ☐ Yes ☐ No

At the time of the collision my body hit: ☐ Nothing ☐ Windshield ☐ Steering wheel ☐ Ceiling ☐ Door ☐ Dashboard ☐ Another body Other_____

Articles inside the vehicle that moved because of the collision: ☐ Nothing ☐ Glasses ☐ Drink ☐ Purse ☐ Papers Other_____

At the time of the collision this part of my body struck something: ☐ Head ☐ Lt shoulder ☐ Rt shoulder ☐ Lt arm/hand ☐ Rt arm/hand ☐ Lt hip/leg ☐ Rt hip/leg ☐ Lt knee ☐ Rt knee ☐ Lt foot ☐ Rt foot Other _____

At the time of the collision my hands were on: ☐ Steering wheel ☐ Stickshift Other_____

At the time of collision my feet were on the: ☐ Brake ☐ Gas ☐ Clutch ☐ Floor Other_____

Did you feel pain immediately after the collision? ☐ Yes ☐ No, ☐ Later that day ☐ Next day Other_____

Where did you feel pain immediately after collision?_____

Where were you taken after accident?_____

Was any Doctor consulted after accident? ☐ No ☐ Yes, Dr._____

Doctor's diagnosis:_____

Treatment given:_____

How often did you see the doctor? (1 time, 2X/wk, etc.)_____

How long did you see the doctor? (# days, weeks or months)_____

Have you ever had any complaints to involved area before? ☐ No ☐ Yes, what were the complaints _____

_____

Because of this automobile collision I have seen: ☐ No one ☐ ER ☐ Medical Doctor ☐ Chiropractor ☐ Physical Therapist ☐ Massage Therapist Other_____

Because of this accident I am: ☐ Taking medication ☐ Taking NO medication

Were there any broken bones as a result of this accident? ☐ Yes ☐ No

If yes, what_____

☐ ☐

If yes, list dates_____

Before this injury, were you capable of working on an equal basis with others your age? ☐ Yes ☐ No

Are your work activities restricted as a result of this accident? ☐ No ☐ Yes, list_____

Have you had any accidents or trauma since this automobile collision? ☐ Yes ☐ No

If yes, list_____

Since this injury, your symptoms have: ☐ Improved ☐ Gotten Worse ☐ Remained the Same

Patient Signature_____**Date**_____