AUTOMOBILE ACCIDENT QUESTIONNAIRE

Name: _____ Date: _____
Date of accident: _____
Type of vehicle you were in: _____
Other vehicle type: _____
Were you the driver? _____
If you were the passenger, where were you sitting? _____
Were you wearing a seatbelt? _____Were you wearing a lap belt?_____
Did your vehicle have an airbag? _____ If so, did it deploy? _____
What were the road conditions? (wet, dry, icy, gravel, pavement) _____
Type of impact? (side, front, rear-end) _____
Was your vehicle stopped or moving at the moment of impact? _____
How much damage was sustained by the vehicles in the accident? _____
_____
Was your vehicle drivable after the accident? _____
Were you aware the accident was going to happen? _____
Did you brace yourself? _____
How many vehicles in the collision? _____
Were you knocked unconscious? _____
How did you feel immediately following the collision? _____
How did you feel hours or days later? _____
Did you go to the emergency room? Y/N If so, what was done at the ER?_____
_____
Have you had any treatments before coming to my office today? Y/N If so, what? _____
_____
How did you respond to this treatment? _____
_____
Have you lost time from work due to this accident? _____
Did this accident occur in the course of your work? _____
Have you had an automobile accident in the past? Y/N If so, what areas of the body were injured? _____
What symptoms were you having before this collision? _____
_____
Have you retained an attorney? Y/N If so, name and address. _____
_____