AUTOMOBILE ACCIDENT QUESTIONNAIRE

Name:____ Date:__________________

Date of Accident:___________________________

The following questions pertain to you and the vehicle you were in:

Vehicle Type:

Vehicle Size:

❑ Car ❑ Compact ❑ Mid-size ❑ Full-size ❑ Station Wagon

❑ Truck ❑ Regular Cab ❑ Extended Cab ❑ Super Cab

❑ Van ❑ Mini ❑ Regular size ❑ Extended ❑ Heavy Duty

❑ Bus ❑ School ❑ Commercial

❑ Other___________________________

Your Position in the vehicle:

❑ Driver

❑ Passenger ❑ Front ❑ Back ❑ Left ❑ Right ❑ Middle

❑ Other:________________

Speed of your vehicle:

❑ Stopped Why stopped? ❑ Stop sign/red light ❑ Parked

❑ Slowing down

❑ Speed Limit

❑ Moving at approximately _____ mph

Collision Type:

❑ Driver Side Impact ❑ Passenger Side Impact

❑ Head-on Collision ❑ Rear-end Collision

❑ Front Impact ❑ Rear Impact

The following questions concern the other vehicle involved in the accident:

Vehicle Type:

Vehicle Size:

❑ Car ❑ Compact ❑ Mid-size ❑ Full-size ❑ Station Wagon

❑ Truck ❑ Regular Cab ❑ Extended Cab ❑ Super Cab

❑ Van ❑ Mini ❑ Regular size ❑ Extended ❑ Heavy Duty

❑ Bus ❑ School ❑ Commercial

❑ Other___________________________

Conditions at the time of the accident:

Time of Day:

❑ Full daylight ❑ Night ❑ Dawn ❑ Dusk

Road Conditions:

❑ Dry ❑ Wet ❑ Rain ❑ Snow ❑ Ice ❑ 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…

❑ Seatbelt ❑ Shoulder Harness ❑ None

If you were the driver of the vehicle, was your foot on the brake pedal? ❑ Yes ❑ No

Was the airbag deployed? ❑ Yes ❑ No ❑ No air bag in my vehicle

What position was your headrest: ❑ High ❑ Middle ❑ Low

Position of your head at time of impact?

❑ Facing Straight Ahead ❑ Tilted Forward ❑ Tilted Backward

❑ Rotated: ❑ Left ❑ Right

Was your head thrown…?

❑ Backwards and then Forward ❑ Forward and then Backwards

❑ To the Left then to the Right ❑ To the Right then to the Left

❑ Not thrown

Position of your body at the time of impact?

❑ Straight ❑ Tilted forward ❑ Tilted backward

❑ Rotated: ❑ Left ❑ Right

Was your body thrown…?

- ❑ Backward and then Forward
- ❑ Forward and then Backwards
- ❑ To the Left and then Right
- ❑ To the Right and then Left
- ❑ Across the vehicle
- ❑ Outside the vehicle
- ❑ Not thrown

Damage to the vehicle YOU were in:

- ❑ Minimal Damage
- ❑ Moderate Damage
- ❑ Severe Damage
- ❑ Was Totaled
- ❑ Don't Know

As a result of the force of the collision/impact, which objects in the vehicle did your body strike?

Head:

❑ Steering Wheel ❑ Dashboard ❑ Windshield ❑ Side Window ❑ Rear Mirror

Left Arm:

❑ Steering Wheel ❑ Side Window ❑ Console ❑ Gear Shift ❑ Door

Right Arm:

❑ Steering Wheel ❑ Side Window ❑ Console ❑ Gear Shift ❑ Door

Torso:

❑ Steering Wheel ❑ Dashboard ❑ Console ❑ Door

Left Leg:

❑ Steering Wheel ❑ Dashboard ❑ Console ❑ Gear Shift ❑ Door

Right Leg:

❑ Steering Wheel ❑ Dashboard ❑ Console ❑ Gear Shift ❑ Door

<u>The following questions concern the time period immediately following the accident:</u>

Did you lose consciousness? ❑ Yes ❑ No

Immediately following the accident, did you feel…

❑ Dizzy ❑ Dazed ❑ Nervous ❑ Weak ❑ Disoriented ❑ Nauseated

Were you able to walk unaided? ❑ Yes ❑ No

Where did you go?

- ❑ Drove Home ❑ Was Driven Home
- ❑ Drove to Work ❑ Was Driven to Work
- ❑ Drove to School ❑ Was Driven to School
- ❑ Drove to Hospital ❑ Was Driven to Hospital

Next day discomfort: ❑ Increased ❑ Decreased ❑ Same

Did your major complaints exist before the accident? ❑ Yes ❑ No

In what areas did you <u>immediately</u> feel pain?

- ❑ Head: ❑ Right ❑ Left ❑ Front ❑ Back ❑ Top
- ❑ Neck: ❑ Right ❑ Left ❑ Front ❑ Back
- ❑ Shoulders: ❑ Right ❑ Left
- ❑ Upper Back: ❑ Right ❑ Left ❑ Center
- ❑ Mid Back: ❑ Right ❑ Left ❑ Center
- ❑ Low Back: ❑ Right ❑ Left ❑ Center
- ❑ Arms: ❑ Right ❑ Left ❑ Upper Arm ❑ Forearm
- ❑ Legs: ❑ Right ❑ Left ❑ Upper Leg ❑ Lower Leg
- ❑ Chest: ❑ Right ❑ Left ❑ Center
- ❑ Abdomen: ❑ Right ❑ Left ❑ Center

In what areas did you experience lacerations (cuts)?

- ❑ Head: ❑ Right ❑ Left ❑ Front ❑ Back ❑ Top
- ❑ Neck: ❑ Right ❑ Left ❑ Front ❑ Back
- ❑ Shoulders: ❑ Right ❑ Left
- ❑ Upper Back: ❑ Right ❑ Left ❑ Center
- ❑ Mid Back: ❑ Right ❑ Left ❑ Center
- ❑ Low Back: ❑ Right ❑ Left ❑ Center
- ❑ Arms: ❑ Right ❑ Left ❑ Upper Arm ❑ Forearm
- ❑ Legs: ❑ Right ❑ Left ❑ Upper Leg ❑ Lower Leg
- ❑ Chest: ❑ Right ❑ Left ❑ Center
- ❑ Abdomen: ❑ Right ❑ Left ❑ Center

At the hospital, what areas were X-Rayed?

❑ Head:	❑ Right	❑ Left	❑ Front	❑ Back	❑ Top
❑ Neck:	❑ Right	❑ Left	❑ Front	❑ Back	
❑ Shoulders:	❑ Right	❑ Left			
❑ Upper Back:	❑ Right	❑ Left	❑ Center		
❑ Mid Back:	❑ Right	❑ Left	❑ Center		
❑ Low Back:	❑ Right	❑ Left	❑ Center		
❑ Arms:	❑ Right	❑ Left	❑ Upper Arm	❑ Forearm	
❑ Legs:	❑ Right	❑ Left	❑ Upper Leg	❑ Lower Leg	
❑ Chest:	❑ Right	❑ Left	❑ Center		
❑ Abdomen:	❑ Right	❑ Left	❑ Center		

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

❑ Head:	❑ Right	❑ Left	❑ Front	❑ Back	❑ Top
❑ Neck:	❑ Right	❑ Left	❑ Front	❑ Back	
❑ Shoulders:	❑ Right	❑ Left			
❑ Upper Back:	❑ Right	❑ Left	❑ Center		
❑ Mid Back:	❑ Right	❑ Left	❑ Center		
❑ Low Back:	❑ Right	❑ Left	❑ Center		
❑ Arms:	❑ Right	❑ Left	❑ Upper Arm	❑ Forearm	
❑ Legs:	❑ Right	❑ Left	❑ Upper Leg	❑ Lower Leg	
❑ Chest:	❑ Right	❑ Left	❑ Center		
❑ Abdomen:	❑ Right	❑ Left	❑ Center		

Signature____ Date________________