

PATIENT AUTOMOBILE COLLISION QUESTIONNAIRE

NAME: \_\_\_\_\_  
Last First MI

Date of Accident: \_\_\_\_\_ Time: \_\_\_\_\_ AM/PM

Describe how the crash happened:

---

---

---

Describe the vehicle you were in:

Model year and make: \_\_\_\_\_

- Compact car  Mid-sized car  Full sized car  
 S.U.V. / truck  Mini-van / van  Larger than 1-ton vehicle

Describe the other vehicle:

Model year and make: \_\_\_\_\_

- Compact car  Mid-sized car  Full sized car  
 S.U.V. / truck  Mini-van / van  Larger than 1-ton vehicle

You were:  Driver  Front Passenger  Back Passenger

Your vehicle was hit where?  Rear  Front  Driver side  Passenger side

Speed of your vehicle?  Stopped  Slow  Moderate  Fast Approx. \_\_\_\_\_ MPH

Speed of other vehicle?  Stopped  Slow  Moderate  Fast Approx. \_\_\_\_\_ MPH

Check **ALL** that apply to you during the crash:

- You were unaware of the impending collision  
 You were aware of the impending collision and relaxed before the collision  
 You were aware of the impending collision and braced yourself  
 Your body, torso, and head were facing straight ahead  
 You had your head and/or torso turned at time of collision  
 Turned to left  Turned to right  
 You were wearing a seat belt

If yes, does your seat belt have a shoulder harness?  Yes  No

You were holding onto the steering wheel at the time of impact

Indicate how your head restraint was positioned at time of crash:

- At the top of the back of your head  
 Midway height of the back of your head  
 Lower height of the back of your head  
 Located at level of your neck or below  
 Unsure

At the time of the accident, list what parts of your head or body hit your vehicle and where on the vehicle they hit:

---

---

Did you lose consciousness?  Yes  No If yes, for how long \_\_\_\_\_

**Please describe how you felt:**

Immediately after the accident: \_\_\_\_\_

Later that day: \_\_\_\_\_

The next day: \_\_\_\_\_

What are your present complaints and symptoms? \_\_\_\_\_

---

---

---

---

What treatment have you received since the accident? (List doctor, type of treatment, results)

---

---

Did you have any physical complaints before the accident?

No  Yes, describe

---

---

List all previous accidents (major & minor), including dates and types, as well as injuries.

---

---

Describe your employment and how much time you have lost from work due to the accident.

---

---

List any activity restrictions as result of this accident:

---

---

Any other pertinent information: \_\_\_\_\_

---

After reading and filling out the above questionnaire, your signature will verify that the information is accurate.

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_