Automobile Accident Questionnaire

Patient's Name _____ Today's Date _____
Date of Accident _____ Hour _____ □ AM □ PM
Location of accident: _____
Describe how accident happened in detail: _____
_____
_____
_____

In the Accident:

Were you the □ Driver □ Passenger □ Pedestrian Where were you seated in the vehicle? _____
Did you strike the other vehicle? □ Yes □ No Did the other vehicle strike you? □ Yes □ No
Were you struck from: □ Behind □ Front □ Left side □ Right side
Were traffic citations issued to: □ You □ Driver of your car □ Driver of other car □ None
Was your car heading: □ North □ South □ East □ West on _____ (street or highway)
Was the other car heading: □ North □ South □ East □ West on _____ (street or highway)

Were you aware of the impending impact/accident? □ Yes □ No
Were you wearing your seat belt? □ Yes □ No
Which way was you head facing upon impact: □ Straight ahead □ Turned around □ Up at mirror

Describe in detail your symptoms immediately following the accident: _____
_____
_____

Check symptoms you have had since the accident:

□ Headache	□ Irritability	□ Short breath	□ Loss of smell
□ Neck Pain	□ Lower back pain	□ Fatigue	□ Loss of taste
□ Neck stiffness	□ Chest pain	□ Depression	□ Diarrhea
□ Sleeping problems	□ Pins/needles in arms	□ Loss of memory	□ Constipation
□ Upper back pain	□ Pins/needles in legs	□ Ears ringing	□ Cold feet/hands
□ Shoulder pain	□ Numbness in fingers	□ Loss of balance	□ Upset stomach
□ Tension	□ Numbness in toes	□ Fainting	□ Sweats/fever

Symptoms Other than above: _____
_____

Have you lost time from work? □ Yes □ No Dates from _____ to _____
Did you require hospitalization? □ Yes □ No □ Emergency Room Only
If hospitalized, date admitted _____ date discharged _____
Name of Hospital _____
Address: _____
Attending Physician: _____