

AUTOMOBILE ACCIDENT QUESTIONNAIRE

Dr. Harvey Abrams, D.C., FIAMA
801 S. Power Rd. Ste 107
Mesa, AZ 85206
(480) 396-4400

Patient's Name: _____
Today's Date: _____
Date of Accident: _____

THE FOLLOWING QUESTIONS PERTAIN TO YOU AND THE VEHICLE YOU WERE IN:

Your position in the vehicle:

- Driver Passenger ----- Location-----
 Left Middle Right Other _____
 Front Passenger Rear Passenger Third Seat (rear)

Vehicle size:

- Subcompact Full-size
 Compact Mini
 Mid-size Light
 Heavy Other _____

Vehicle type:

- Car Truck Other _____
 Van Bus
 Station Wagon Sport Utility
 Pickup Crossover

Speed of your vehicle:

- Stopped Moving Moderately
 Parked Moving Fast
 Slowing Moving at approx ____ MPH
 Moving Slowly Other _____

Why Vehicle was slowed or stopped:

- Traffic Signal Parking
 Pedestrian Traffic
 Stop Sign Busy Intersection
 Other _____

Collision Type:

- Driver Side Impact Head On Collision
 Passenger Side Impact Rear Impact
 Front Impact Pedestrian Incident Other _____

THE FOLLOWING QUESTIONS CONCERN THE OTHER VEHICLE INVOLVED IN THE ACCIDENT: N/A

Vehicle size:

- Subcompact Light
 Compact Mini
 Mid-size Heavy
 Full-size Other _____

Vehicle type:

- Car Pickup
 Van Truck
 Station Wagon Bus
 Other _____

CONDITIONS AT THE TIME OF THE ACCIDENT: N/A

Time of day:

- Full daylight
 Dawn
 Dusk
 Night
 Other _____

Road Conditions:

- Dry
 Damp
 Wet
 Snow covered
 Ice covered
 Patchy Ice/Snow

Visibility:

- Excellent
 Good
 Fair
 Poor
 Other _____

Visibility compromised by:

- Brightness
 Darkness
 Rain
 Snow
 Fog
 Traffic

THE FOLLOWING QUESTIONS CONCERN THE MOMENT OF IMPACT OF THE ACCIDENT: N/A

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: (check all that apply)

- Seat belt
 Shoulder harness
 No restraints

If you were the driver of the vehicle, was your foot on the brake pedal? Yes No Knocked off by impact

Was the air bag deployed? N/A

- Car not equipped with air bag
 Air bag deployed
 Air bag not deployed

What position was YOUR headrest in? N/A

- High position
 Middle position
 Low position

Position of YOUR head at time of impact? N/A

- Facing straight ahead
- Tilted forward
- Rotated to the left
- Rotated to the right

Was your head thrown...? N/A

- Backward and then forward
- Forward then backward
- To the left To the left then the right
- To the right To the right, then the left

Position of Your body at time of impact? N/A

- Straight
- Tilted forward
- Rotated to the left
- Rotated to the right

Was your body thrown...? N/A

- Backward and then forward
- Forward then backward
 - To the left To the left then the right
 - To the right To the right, then the left
- Across the vehicle
- Outside the vehicle Under the vehicle

Damage to vehicle YOU were in: N/A

- Minimal damage Was totaled
- Moderate damage Not known
- Severe damage Other

Citations: N/A

- None issued Driver of other vehicle
- Yourself Not sure
- Driver of vehicle patient was a passenger of

AS A RESULT OF THE FORCE OF THE COLLISION, WHICH OBJECTS IN THE VEHICLE DID YOUR BODY STRIKE?

Head N/A

- Steering wheel Right door
- Dashboard Left window
- Windshield Right window
- Armrest Console
- Headrest Gear shift
- Rear view mirror Front seat
- Left door Backseat

Left Arm N/A

- Steering wheel Right door
- Dashboard Left window
- Windshield Right window
- Armrest Console
- Headrest Gear shift
- Rear view mirror Front seat
- Left door Backseat

Right Arm N/A

- Steering wheel Right door
- Dashboard Left window
- Windshield Right window
- Armrest Console
- Headrest Gear shift
- Rear view mirror Front seat
- Left door Backseat

Torso N/A

- Steering wheel Right door
- Dashboard Left window
- Windshield Right window
- Armrest Console
- Headrest Gear shift
- Rear view mirror Front seat
- Left door Backseat

Left Leg N/A

- Steering wheel Right door
- Dashboard Left window
- Windshield Right window
- Armrest Console
- Headrest Gear shift
- Rear view mirror Front seat
- Left door Backseat

Right Leg N/A

- Steering wheel Right door
- Dashboard Left window
- Windshield Right window
- Armrest Console
- Headrest Gear shift
- Rear view mirror Front seat
- Left door Backseat

THE FOLLOWING QUESTIONS CONCERN THE TIME PERIOD IMMEDIATELY FOLLOWING THE ACCIDENT:

Did you lose consciousness?

- Yes
- No

Immediately following the accident, did you feel...?

- Dizzy Weak None
- Dazed Nervous Other _____
- Disoriented Nauseated

Were you able to walk unaided?

- Yes
- No

Where did you go...?

- Drove home Drove to work
- Was driven home Was driven to work
- Drove to hospital Drove to school
- Was driven to hospital Was driven to school
- Taken to hospital via ambulance Other _____

Next day discomfort...?

increased decreased same

Did your major complaints exist before the accident?

Yes No

In what areas did you IMMEDIATELY feel pain? N/A

<input type="checkbox"/> Head	Shoulder	<input type="checkbox"/> Left	<input type="checkbox"/> Right	Hip	<input type="checkbox"/> Left	<input type="checkbox"/> Right
<input type="checkbox"/> Neck	Arm	<input type="checkbox"/> Left	<input type="checkbox"/> Right	Thigh	<input type="checkbox"/> Left	<input type="checkbox"/> Right
<input type="checkbox"/> Upper back	Elbow	<input type="checkbox"/> Left	<input type="checkbox"/> Right	Knee	<input type="checkbox"/> Left	<input type="checkbox"/> Right
<input type="checkbox"/> Mid back	Wrist	<input type="checkbox"/> Left	<input type="checkbox"/> Right	Calf	<input type="checkbox"/> Left	<input type="checkbox"/> Right
<input type="checkbox"/> Ribs	Hand	<input type="checkbox"/> Left	<input type="checkbox"/> Right	Ankle	<input type="checkbox"/> Left	<input type="checkbox"/> Right
<input type="checkbox"/> Chest	Fingers	<input type="checkbox"/> Left	<input type="checkbox"/> Right	Foot	<input type="checkbox"/> Left	<input type="checkbox"/> Right
<input type="checkbox"/> Abdomen	Buttock	<input type="checkbox"/> Left	<input type="checkbox"/> Right	Toes	<input type="checkbox"/> Left	<input type="checkbox"/> Right
<input type="checkbox"/> Low Back	<input type="checkbox"/> Pelvis					

In what areas did you experience lacerations (cuts)? N/A

<input type="checkbox"/> Head	Shoulder	<input type="checkbox"/> Left	<input type="checkbox"/> Right	Hip	<input type="checkbox"/> Left	<input type="checkbox"/> Right
<input type="checkbox"/> Neck	Arm	<input type="checkbox"/> Left	<input type="checkbox"/> Right	Thigh	<input type="checkbox"/> Left	<input type="checkbox"/> Right
<input type="checkbox"/> Upper back	Elbow	<input type="checkbox"/> Left	<input type="checkbox"/> Right	Knee	<input type="checkbox"/> Left	<input type="checkbox"/> Right
<input type="checkbox"/> Mid back	Wrist	<input type="checkbox"/> Left	<input type="checkbox"/> Right	Calf	<input type="checkbox"/> Left	<input type="checkbox"/> Right
<input type="checkbox"/> Ribs	Hand	<input type="checkbox"/> Left	<input type="checkbox"/> Right	Ankle	<input type="checkbox"/> Left	<input type="checkbox"/> Right
<input type="checkbox"/> Chest	Fingers	<input type="checkbox"/> Left	<input type="checkbox"/> Right	Foot	<input type="checkbox"/> Left	<input type="checkbox"/> Right
<input type="checkbox"/> Abdomen	Buttock	<input type="checkbox"/> Left	<input type="checkbox"/> Right	Toes	<input type="checkbox"/> Left	<input type="checkbox"/> Right
<input type="checkbox"/> Low Back	<input type="checkbox"/> Pelvis					

At the hospital, what areas were x-rayed? N/A

<input type="checkbox"/> Head	Shoulder	<input type="checkbox"/> Left	<input type="checkbox"/> Right	Hip	<input type="checkbox"/> Left	<input type="checkbox"/> Right
<input type="checkbox"/> Neck	Arm	<input type="checkbox"/> Left	<input type="checkbox"/> Right	Thigh	<input type="checkbox"/> Left	<input type="checkbox"/> Right
<input type="checkbox"/> Upper back	Elbow	<input type="checkbox"/> Left	<input type="checkbox"/> Right	Knee	<input type="checkbox"/> Left	<input type="checkbox"/> Right
<input type="checkbox"/> Mid back	Wrist	<input type="checkbox"/> Left	<input type="checkbox"/> Right	Calf	<input type="checkbox"/> Left	<input type="checkbox"/> Right
<input type="checkbox"/> Ribs	Hand	<input type="checkbox"/> Left	<input type="checkbox"/> Right	Ankle	<input type="checkbox"/> Left	<input type="checkbox"/> Right
<input type="checkbox"/> Chest	Fingers	<input type="checkbox"/> Left	<input type="checkbox"/> Right	Foot	<input type="checkbox"/> Left	<input type="checkbox"/> Right
<input type="checkbox"/> Abdomen	Buttock	<input type="checkbox"/> Left	<input type="checkbox"/> Right	Toes	<input type="checkbox"/> Left	<input type="checkbox"/> Right
<input type="checkbox"/> Low Back	<input type="checkbox"/> Pelvis					

Where did you experience pain on the day FOLLOWING the accident? N/A

<input type="checkbox"/> Head:	<input type="checkbox"/> Left	<input type="checkbox"/> Right	<input type="checkbox"/>	Shoulder:	<input type="checkbox"/> Left	<input type="checkbox"/> Right	Hip	<input type="checkbox"/> Left	<input type="checkbox"/> Right
<input type="checkbox"/> Neck:	<input type="checkbox"/> Left	<input type="checkbox"/> Right	<input type="checkbox"/>	Arm:	<input type="checkbox"/> Left	<input type="checkbox"/> Right	Thigh	<input type="checkbox"/> Left	<input type="checkbox"/> Right
<input type="checkbox"/> Upper back:	<input type="checkbox"/> Left	<input type="checkbox"/> Right	<input type="checkbox"/>	Elbow:	<input type="checkbox"/> Left	<input type="checkbox"/> Right	Knee	<input type="checkbox"/> Left	<input type="checkbox"/> Right
<input type="checkbox"/> Mid back:	<input type="checkbox"/> Left	<input type="checkbox"/> Right	<input type="checkbox"/>	Wrist	<input type="checkbox"/> Left	<input type="checkbox"/> Right	Calf	<input type="checkbox"/> Left	<input type="checkbox"/> Right
<input type="checkbox"/> Ribs:	<input type="checkbox"/> Left	<input type="checkbox"/> Right	<input type="checkbox"/>	Hand	<input type="checkbox"/> Left	<input type="checkbox"/> Right	Ankle	<input type="checkbox"/> Left	<input type="checkbox"/> Right
<input type="checkbox"/> Chest:	<input type="checkbox"/> Left	<input type="checkbox"/> Right	<input type="checkbox"/>	Fingers	<input type="checkbox"/> Left	<input type="checkbox"/> Right	Foot	<input type="checkbox"/> Left	<input type="checkbox"/> Right
<input type="checkbox"/> Abdomen:	<input type="checkbox"/> Left	<input type="checkbox"/> Right	<input type="checkbox"/>	Buttock	<input type="checkbox"/> Left	<input type="checkbox"/> Right	Toes	<input type="checkbox"/> Left	<input type="checkbox"/> Right
<input type="checkbox"/> Low Back:	<input type="checkbox"/> Left	<input type="checkbox"/> Right	<input type="checkbox"/>	Pelvis					

Patient's Signature: _____