Erickson Clinic of Chiropractic

AUTOMOBILE ACCIDENT QUESTIONNAIRE

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

Date of Accident:_____

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

Vehicle type:

☐ Car ☐ Pickup
☐ Van ☐ Truck
☐ Station Wagon ☐ Bus
☐ Other_____

Vehicle size:

☐ Subcompact ☐ Full-size
☐ Compact ☐ Mini
☐ Mid-size ☐ Light
☐ Heavy ☐ Other_____

Your position in the vehicle:

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

Speed of your vehicle:

☐ Stopped ☐ Moving Moderately
☐ Parked ☐ Moving Fast
☐ Slowing ☐ Moving at apprx ____MPH
☐ Moving Slowly

Why Vehicle was slowed or stopped:

☐ Traffic Signal ☐ Parking
☐ Pedestrian ☐ Traffic
☐ Stop Sign ☐ Busy Intersection

Collision Type:

☐ Driver Side Impact ☐ Head On Collision
☐ Passenger Side Impact ☐ Rear Impact
☐ Front Impact ☐ Pedestrian Incident

THE FOLLOWING QUESTIONS CONCERN THE OTHER VEHICLE INVOLVED IN THE ACCIDENT:

Vehicle type:

☐ Car ☐ Pickup
☐ Van ☐ Truck
☐ Station Wagon ☐ Bus
☐ Other_____

Vehicle size:

☐ Subcompact ☐ Full-size
☐ Compact ☐ Mini
☐ Mid-size ☐ Light
☐ Heavy ☐ Other_____

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: (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

Position of YOUR head at time of impact?

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

What position was YOUR headrest in?

☐ High position
☐ Middle position
☐ Low position

Was the air bag deployed?

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

Position of Your body at time of impact?

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

Citations:

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

Damage to vehicle YOU were in:

☐ Incurred minimal damage
☐ Incurred moderate damage
☐ Incurred severe damage
☐ Was totaled
☐ Not known

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

Head

- ☐ Steering wheel
- ☐ Dashboard
- ☐ Windshield
- ☐ Armrest
- ☐ Headrest
- ☐ Rear view mirror
- ☐ Left door
- ☐ Right door
- ☐ Left window
- ☐ Right window
- ☐ Console
- ☐ Gear shift
- ☐ Front seat
- ☐ 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
- ☐ Dazed
- ☐ Nervous
- ☐ Disoriented
- ☐ Nauseated

Were you able to walk unaided?

- ☐ Yes
- ☐ No

Where did you go...?

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

Next day discomfort...?

☐ increased ☐ decreased ☐ same

Did your major complaints exist before the accident?

☐ Yes ☐ No

In what areas did you IMMEDIATELY feel pain?

☐ Head	Shoulder	☐ Left	☐ Right
☐ Neck	Arm	☐ Left	☐ Right
☐ Upper back	Elbow	☐ Left	☐ Right
☐ Mid back	Wrist	☐ Left	☐ Right
☐ Ribs	Knee	☐ Left	☐ Right
☐ Chest	Fingers	☐ Left	☐ Right
☐ Abdomen	Buttock	☐ Left	☐ Right

At the hospital, what areas were x-rayed?

☐ Head	Shoulder	☐ Left	☐ Right
☐ Neck			
☐ Upper back			
☐ Mid back			
☐ Low Back			
☐ Pelvis			

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

☐ Head	Shoulder	☐ Left	☐ Right
☐ Neck	Arm	☐ Left	☐ Right
☐ Upper back	Elbow	☐ Left	☐ Right
☐ Mid back	Wrist	☐ Left	☐ Right
☐ Ribs	Hand	☐ Left	☐ Right
☐ Chest	Knee	☐ Left	☐ Right
☐ Abdomen	Buttock	☐ Left	☐ Right
☐ Low Back			
☐ Pelvis			