

AUTO ACCIDENT QUESTIONNAIRE

Name: _____
Date of Accident: _____

File #: _____
Date: _____

1. Describe in your own words how the accident happened. _____

Draw a simple diagram to illustrate

----When possible, circle your answer----

2. What position were you seated in?(driver's seat, front passenger, rear passenger behind driver(left), rear passenger on right, other _____
How many people were in your vehicle? _____

3. Please describe your vehicle:

Year _____ Make _____ Model _____ ?
Car, truck, p/u, bus, minivan, SUV
Estimate the damage to your vehicle: (none, mild, moderate, heavy, totaled)

4a. Please describe other vehicle(s):

Year _____ Make _____ Model _____ ?
Car, truck, p/u, bus, minivan, SUV
Estimate the damage to the other vehicle: (none, mild, moderate, heavy, totaled)

b. Please estimate the following as accurately as possible:

The speed of your vehicle _____ MPH
The speed of the other vehicle _____ MPH

5. Were your brakes on at the time of impact? Yes / No

6. Were you prepared for impending collision? Yes / No

If yes, were you _____ Able to brace yourself for the impact? How (ex: gripping the steering wheel, door handle, etc.)? _____
_____ Happened too fast. _____

7. Please describe the position of your body just prior to impact (ex: leaning forward slightly, head turned to (right, left), arm out window, (right) hand on steering wheel, etc...) _____

8. Please describe what happened during the accident (ex: "head whipped back striking headrest, then I was thrown forward, (right) knee struck stick shift, etc..") _____

(Turn over)

16. What parts of your vehicle were damaged?

Front bumper, Nose R/L Front fenders, Tires, Windshield
Back bumper, Trunk R/L Front/Back doors,
R/L Back fenders, Tires

17. What parts of the other vehicle were damaged?

Front bumper, Nose R/L Front fenders, Tires, Windshield
Back bumper, Trunk R/L Front/Back doors
R/L Back fenders, Tires

AFTER THE ACCIDENT

18. Please describe how you felt immediately after the accident(*angry, upset, shocked, OK, neck pain, back pain, etc...*) _____

19. Were you better or worse the next day? _____

20. Were you taken to an Emergency Room? (Yes / No)

If yes, which one?: *St. Mary's / Waterbury/ Midstate/Other* _____

a. Were you taken by: *ambulance / spouse / friend* ?

b. If you went to the Emergency Room, when did you go?

(*from the scene/ later same day/ next day/ other* _____)

22. What treatment have you received ? **X-rays** (*neck, back, shoulder, knee, _____*)
CT Scan (head) **MRI** _____ **Medication:**(*Flexeril, Ibuprofen, Motrin, Vicodin Soma, Vioxx, Oxycodone, Cyclobenzeprene, Percocet, Valium, Tylenol w/ Codine, Celebrex Skelaxin.* **Instructed to:**(*rest, apply ice, heating pad, take: Motrin-Tylenol-Alieve*)

23. Have you lost any time from work as a result of the accident? Yes / No

If YES, From _____ To _____ (currently)

Place of Employment _____ Type of work _____

24. Have you seen any other doctors for this condition? (Yes / No)

Who? _____

What type of treatment was provided? (*Medication, therapy or referral for therapy, instructed to rest, disabled from work,* _____)

PREVIOUS INJURIES

25. Have you ever been involved in any previous motor vehicle accidents? (Y / N)

IF YES: a) Were you injured ? (Y / N) (b) When ? _____

c) What was injured ? (*neck, back, shoulder, knees, other* _____)

d) Did you receive any treatment? (Y / N) Where ? _____

e) Did you ever receive a disability or impairment rating? Explain _____

26. Have you ever had any previous injuries to your neck or back ? (Y / N)

IF YES: a) When ? _____ b) Did you receive any treatment? (Y / N)

c) Where ? _____