

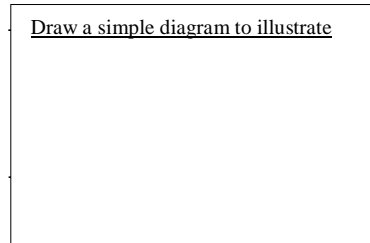
AUTO ACCIDENT QUESTIONNAIRE

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)

9a. Were you rendered unconscious? Yes / No

b. If “yes”, for how long? (estimate) _____

10. Did you receive any fractures (broken bones), cuts, bruises or abrasions?

Yes / No If “yes”, Describe: _____

11. Did you strike your (Circle as many as apply):

- A) Head Against the: 1) Dashboard 2) Windshield 3) Steering Wheel
 4) Rt. Door 5) Lft. Door 6) Head Restraint
- B) Shoulder (R, L) Against the: 1) Dashboard 2) Windshield 3) Steering Wheel
 4) Rt. Door 5) Lft. Door 6) Head Restraint
- C) Arm (R, L) Against the: 1) Dashboard 2) Windshield 3) Steering Wheel
 4) Rt. Door 5) Lft. Door 6) Head Restraint
- D) Elbow (R, L) Against the: 1) Dashboard 2) Windshield 3) Steering Wheel
 4) Rt. Door 5) Lft. Door 6) Head Restraint
- E) Hand (R, L) Against the: 1) Dashboard 2) Windshield 3) Steering Wheel
 4) Rt. Door 5) Lft. Door 6) Head Restraint
- F) Hip (R, L) Against the: 1) Dashboard 2) Windshield 3) Steering Wheel
 4) Rt. Door 5) Lft. Door 6) Head Restraint
- G) Knee (R, L) Against the: 1) Dashboard 2) Windshield 3) Steering Wheel
 4) Rt. Door 5) Lft. Door 6) Head Restraint
- H) Ankle (R, L) Against the: 1) Dashboard 2) Windshield 3) Steering Wheel
 4) Rt. Door 5) Lft. Door 6) Head Restraint

VEHICLE

11a. Is your car equipped with head rests? Yes / No

b. They are: adjustable / Part of the seat back

c. If adjustable, how were they adjusted?

Low / Midposition / High

12a. Were you wearing seatbelts? Yes / No

b. Were you wearing a shoulder harness? Yes / No

13a. Were you wearing a hat or glasses? Yes / No

b. If yes, were they thrown off your head by the accident? Yes / No

14. How was your seat back adjusted?

___ Straight up (90 degrees) ___ Slightly reclined(15 degrees)

___ Reclined (30 degrees)

15a. Was your seat damaged by the accident? Yes / No

b. Was your steering wheel damaged? Yes / No

c. Did airbags deploy? Yes / No / Not equipped

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 (*disoriented, 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, Oxycodone, Cyclobenzeprene, Percocet, Valium, Tylenol w/ Codine, Naproxen, 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 ? _____