Form 102
81904

AUTO ACCIDENT QUESTIONAIRE

Name: _____ **File #: _____**
Date of Accident:_____ **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 ? _____