

AUTOMOBILE ACCIDENT QUESTIONNAIRE

Please answer all questions completely

DATE: _____ NAME: _____

DATE AND TIME OF ACCIDENT: _____

CITY AND STREET OF ACCIDENT: _____

ROAD CONDITIONS AT THE TIME OF THE ACCIDENT: Wet Dry Icy Other _____

DID THE POLICE COME TO THE ACCIDENT SCENE? _____

1. Were you: Driver Passenger Front Seat Back Seat

2. Were you wearing a seat belt ____; If "yes" (then, was it a lap seat belt or a shoulder lap seat belt?)

3. How far is the headrest or seat back from the top of your head? _____
Inches above – below (Approximately).

4. List the year, _____ make, _____ and model _____
of the vehicle you were in?

5. What is the year, _____ make, _____ and model _____
of the other vehicle that struck you?

6. Was your car stopped at the time of impact? _____ If "yes", was the driver's foot also on the
brake? _____. If "no", then estimate the speed of the vehicle you were in _____
miles/hour.

7. Were you aware of the approaching collision prior to impact, or did the impact catch you by
surprise? _____.

8. You were struck from: Behind Front Left Side Right Side Chain reaction Non-collision.

9. Was your head pointed straight forward? _____. If "no", what direction was it turned, and by
how much? _____?

10. Did any of your body parts hit any part of the inside of the car? _____ If "yes", please explain in
detail: _____

11. Were you knocked unconscious? _____ How Long? _____

12. Were you shaken, stunned or disoriented immediately following the accident? _____

13. What bruises did you get during this accident? _____

14. What bleeding cuts did you receive during the accident? _____

15. Where did you feel pain immediately following the accident? _____

16. Please describe, to the best of your knowledge, what happened during the accident:

17. What is the cost damage to the vehicle you were in? \$ _____
18. Did paramedics evaluate you at the scene? _____. If "yes", did the paramedics administer any type of treatment while at the accident scene? _____
19. Were you taken to the hospital? _____ If "yes", name and location: _____

20. How did you get to the hospital? _____
21. At the hospital, were you admitted or discharged? _____
What treatments did you receive while you were there? _____

22. What parts of the body were x-rayed at the hospital? _____
23. Did you receive any sutures (stitches) while you were there? _____
If so, where and how many _____
24. Since the accident are your symptoms improving, same or getting worse? _____
25. Have you ever had any complaints in the involved areas before? Yes _____ No _____
26. If you have been in any previous auto accidents, please list the year each was in?
A. _____
B. _____
C. _____
- Signature: _____ Date: _____