SMITH CHIROPRACTIC CLINIC
AUTOMOBILE ACCIDENT QUESTIONNAIRE

Patient's Name: ______________________________ Today's Date: __________

Date of Accident: ____________________________ Location: ______________

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
- ❑ Front Passenger -------- Location-------- ❑Rear Passenger ❑Third Seat (rear)
- ❑Other _________________ ❑Left ❑Middle ❑Right

Speed of your vehicle:
- ❑Stopped ❑Moving Moderately
- ❑Parked ❑Moving Fast
- ❑Slowing
- ❑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
- ❑Other________________

Vehicle size:
- ❑Subcompact ❑Full-size
- ❑Compact ❑Mini
- ❑Bus ❑Mid-size ❑Light
- ❑Heavy ❑Other_________________

CONDITIONS AT THE TIME OF THE ACCIDENT:

Time of day:	Road Conditions:	Visibility:	Visibility compromised by:
❑Full daylight	❑Dry	❑Excellent	❑Brightness
❑Dawn	❑Damp	❑Good	❑Darkness
❑Dusk	❑Wet	❑Fair	❑Rain
❑Night	❑Snow covered	❑Poor	❑Snow
	❑Ice covered		❑Fog
	❑Patchy Ice/Snow		❑Traffic

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

Was the air bag deployed?
- ❑Car not equipped with air bag
- ❑Air bag deployed
- ❑Air bag not deployed

What position was YOUR headrest in?
- ❑High position
- ❑Middle position
- ❑ Low position

Position of YOUR head at time of impact?
- ❑Facing straight ahead
- ❑Tilted forward
- ❑Rotated to the left
- ❑Rotated to the right

Was your head thrown...?
- ❑Backward and then forward
- ❑Forward then backward
- ❑To the left ❑To the left then the right
- ❑To the right ❑To the right, then the left

Position of Your body at time of impact?
- ❑Straight
- ❑Tilted forward
- ❑Rotated to the left
- ❑Rotated to the right

Was your body thrown...?
- ❑Backward and then forward
- ❑Forward then backward
- ❑To the left ❑To the left then the right
- ❑To the right ❑To the right, then the left
- ❑Across the vehicle
- ❑Outside the vehicle ❑Under the vehicle

Damage to vehicle YOU were in:
- ❑Incurred minimal damage
- ❑Incurred moderate damage
- ❑Incurred severe damage
- ❑Was totalled
- ❑Not known

Citations:
- ❑None issued
- ❑Yourself
- ❑Driver of vehicle patient was a passenger of
- ❑Driver of other vehicle
- ❑Not sure

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

CHECK ALL THAT APPLY

Head
- ❑Steering wheel
- ❑Dashboard
- ❑Windshield
- ❑Armrest
- ❑Headrest
- ❑Rear view mirror
- ❑Left door
- ❑Right door
- ❑Left window
- ❑Right window
- ❑Console
- ❑Gear shift
- ❑Front seat
- ❑Backseat

Left Arm
- ❑Steering wheel
- ❑Dashboard
- ❑Windshield
- ❑Armrest
- ❑Headrest
- ❑Rear view mirror
- ❑Left door
- ❑Right door
- ❑Left window
- ❑Right window
- ❑Console
- ❑Gear shift
- ❑Front seat
- ❑Backseat

Right Arm

❑Steering wheel	❑Right door
❑Dashboard	❑Left window
❑Windshield	❑Right window
❑Armrest	❑Console
❑Headrest	❑Gear shift
❑Rear view mirror	❑Front seat
❑Left door	❑Backseat

Torso/Body

❑Steering wheel	❑Right door
❑Dashboard	❑Left window
❑Windshield	❑Right window
❑Armrest	❑Console
❑Headrest	❑Gear shift
❑Rear view mirror	❑Front seat
❑Left door	❑Backseat

Left Leg

❑Steering wheel	❑Right door
❑Dashboard	❑Left window
❑Windshield	❑Right window
❑Armrest	❑Console
❑Headrest	❑Gear shift
❑Rear view mirror	❑Front seat
❑Left door	❑Backseat

Right Leg

❑Steering wheel	❑Right door
❑Dashboard	❑Left window
❑Windshield	❑Right window
❑Armrest	❑Console
❑Headrest	❑Gear shift
❑Rear view mirror	❑Front seat
❑Left door	❑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	❑Drove to work
❑Was driven home	❑Was driven to work
❑Drove to hospital	❑Drove to school
❑Was driven to hospital	❑Was driven to school

❑Taken to hospital via ambulance Hospital ________________

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	Hip	❑Left	❑Right
❑Neck	Arm	❑Left	❑Right	Thigh	❑Left	❑Right
❑Upper back	Elbow	❑Left	❑Right	Knee	❑Left	❑Right
❑Mid back	Wrist	❑Left	❑Right	Calf	❑Left	❑Right
❑Ribs	Hand	❑Left	❑Right	Ankle	❑Left	❑Right
❑Chest	Fingers	❑Left	❑Right	Foot	❑Left	❑Right
❑Abdomen	Buttock	❑Left	❑Right	Toes	❑Left	❑Right
❑Low Back ❑Pelvis						

In what areas did you experience lacerations (cuts)?

❑Head	Shoulder	❑Left	❑Right	Hip	❑Left	❑Right
❑Neck	Arm	❑Left	❑Right	Thigh	❑Left	❑Right
❑Upper back	Elbow	❑Left	❑Right	Knee	❑Left	❑Right
❑Mid back	Wrist	❑Left	❑Right	Calf	❑Left	❑Right
❑Ribs	Hand	❑Left	❑Right	Ankle	❑Left	❑Right
❑Chest	Fingers	❑Left	❑Right	Foot	❑Left	❑Right
❑Abdomen	Buttock	❑Left	❑Right	Toes	❑Left	❑Right
❑Low Back ❑Pelvis						

At the hospital, what areas were X-Rayed/ MRI/ CT Scan (circle which one applies)

❑Head	Shoulder	❑Left	❑Right	Hip	❑Left	❑Right
❑Neck	Arm	❑Left	❑Right	Thigh	❑Left	❑Right
❑Upper back	Elbow	❑Left	❑Right	Knee	❑Left	❑Right
❑Mid back	Wrist	❑Left	❑Right	Calf	❑Left	❑Right
❑Ribs	Hand	❑Left	❑Right	Ankle	❑Left	❑Right
❑Chest	Fingers	❑Left	❑Right	Foot	❑Left	❑Right
❑Abdomen	Buttock	❑Left	❑Right	Toes	❑Left	❑Right
❑Low Back ❑Pelvis						

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

❑Head	Shoulder	❑Left	❑Right	Hip	❑Left	❑Right
❑Neck	Arm	❑Left	❑Right	Thigh	❑Left	❑Right
❑Upper back	Elbow	❑Left	❑Right	Knee	❑Left	❑Right
❑Mid back	Wrist	❑Left	❑Right	Calf	❑Left	❑Right
❑Ribs	Hand	❑Left	❑Right	Ankle	❑Left	❑Right
❑Chest	Fingers	❑Left	❑Right	Foot	❑Left	❑Right
❑Abdomen	Buttock	❑Left	❑Right	Toes	❑Left	❑Right
❑ Low Back ❑Pelvis						

What medications if any were prescribed: ____

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Patient's Signature: ____ Date: _______/____/________