AUTOMOBILE ACCIDENT QUESTIONNAIRE

Patient's Name:_____ Today's Date:_____

Date of Accident:_____

THE FOLLOWING QUESTIONS PERTAIN TO YOU AND THE VEHICLE YOU WERE IN:

Vehicle type:

- ❑Car
- ❑Van
- ❑Station Wagon
- ❑Pickup
- ❑Truck
- ❑Bus
- ❑Other_____

Vehicle size:

- ❑Subcompact
- ❑Compact
- ❑Mid-size
- ❑Heavy
- ❑Full-size
- ❑Mini
- ❑Light
- ❑Other_____

Your position in the vehicle:

❑Driver

❑Passenger ——— Location——— ❑Left ❑Middle ❑Right

❑Other _____ ❑Front Passenger ❑Rear Passenger ❑Third Seat (rear)

Speed of your vehicle:

- ❑Stopped
- ❑Parked
- ❑Slowing
- ❑Moving Slowly
- ❑Moving Moderately
- ❑Moving Fast
- ❑Moving at apprx ____MPH

Why Vehicle was slowed or stopped:

- ❑Traffic Signal
- ❑Pedestrian
- ❑Stop Sign
- ❑Parking
- ❑Traffic
- ❑Busy Intersection

Collision Type:

- ❑Driver Side Impact
- ❑Passenger Side Impact
- ❑Front Impact
- ❑Head On Collision
- ❑Rear Impact
- ❑Pedestrian Incident

THE FOLLOWING QUESTIONS CONCERN THE OTHER VEHICLE INVOLVED IN THE ACCIDENT:

Vehicle type:

- ❑Car
- ❑Van
- ❑Station Wagon
- ❑Other_____
- ❑Pickup
- ❑Truck
- ❑Bus

Vehicle size:

- ❑Subcompact
- ❑Compact
- ❑Mid-size
- ❑Heavy
- ❑Full-size
- ❑Mini
- ❑Light
- ❑Other_____

CONDITIONS AT THE TIME OF THE ACCIDENT:

Time of day:

- ❑Full daylight
- ❑Dusk
- ❑Night

Road Conditions:

- ❑Dry
- ❑Damp
- ❑Wet
- ❑Snow covered
- ❑Ice covered
- ❑Patchy Ice/Snow

Visibility:

- ❑Excellent
- ❑Good
- ❑Fair
- ❑Poor

Visibility compromised by:

- ❑Brightness
- ❑Darkness
- ❑Rain
- ❑Snow
- ❑Fog
- ❑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?

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

Torso

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

Left Leg

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

Right Leg

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

THE FOLLOWING QUESTIONS CONCERN THE TIME PERIOD IMMEDIATELY FOLLOWING THE ACCIDENT:

Did you lose consciousness? **Immediately following the accident, did you feel...?**

❑Yes ❑Dizzy ❑Weak
❑No ❑Dazed ❑Nervous
❑Disoriented ❑Nauseated

Were you able to walk unaided? **Where did you go...?**

❑Yes ❑Drove home ❑Drove to work
❑No ❑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

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?

❑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

Patient's Signature:_____

AUTO INSURANCE INFORMATION

Your Auto Insurance Company:

Name of Company_____

Address_____
Street/P.O. Box City State Zip

Telephone Number_____ Agent's Name_____

Policy Or Claim Number_____

Do you have medical coverage on your policy?____Yes ____No

Other Driver's Auto Insurance Company:

Name of Company_____

Address_____
Street/P.O. Box City State Zip

Telephone Number_____ Adjuster's Name_____

Policy Or Claim Number_____

Name of Insured_____

Do you have an attorney? ____yes ____No

If yes, Name of Attorney_____

Address_____
Street/P.O. Box City State Zip

Telephone Number_____

Have you been contacted by an Insurance Adjuster or Company responsible for this claim?_____

I authorize the release of any medical or other information necessary to process my claim. I also authorize payment of medical benefits to Dr. Dennis R. Olson for services provided.

Signature_____Date_____