Automobile Crash Questionnaire

Name: _____ Date _____

I. Date & Time of Injury:

Date _____ Time _____:_____ am/pm

In your own words please describe the accident?

_____

_____

_____

II. Your Vehicle:

1. Vehicle Type?

☐ Car ☐ Van ☐ Pickup ☐ Truck
☐ Bus ☐ Station Wagon
☐ Other _____

2. Vehicle Size?

☐ Mini ☐ Light ☐ Subcompact
☐ Compact ☐ Mid-size ☐ Full-size
☐ Other _____

3. What was your location in the vehicle?

☐ Driver ☐ Passenger ☐ Rear
If Passenger, where?:
☐ Left ☐ Middle ☐ Right
☐Other _____

4. What was the vehicle you were in doing?

☐ Stopping ☐ Slowing down
☐ Moving _____ MPH ☐ Accelerating
☐ Other _____

5. What damage did the vehicle you were in sustain?

☐ Minimal ☐ Moderate ☐ Extensive
☐ Totaled ☐ Unsure
☐ Other _____

III. Other Vehicle(s) Involved in Accident:

1. First Vehicle to strike your vehicle?

a. Vehicle type?

☐ Car ☐ Van ☐ Pickup ☐ Truck
☐ Bus ☐ Station Wagon
☐ Other _____

b. Vehicle Size

☐ Mini ☐ Light ☐ Subcompact
☐ Compact ☐ Mid-size ☐ Full-size
☐ Other _____

c. How did this vehicle strike the vehicle you were in?

☐ Head on ☐ From Right ☐ From Left
☐ Rear ended ☐ Swiped on Right
☐ Swiped on Left
☐Other_____

_____

_____

5. What damage did the other vehicle sustain?

☐ Minimal ☐ Moderate ☐ Extensive
☐ Totaled ☐ Unsure
☐ Other_____

6. Were there other vehicles involved in the accident? ☐ YES ☐ NO
Explain: _____
_____

7. Was a citation given for yourself or the other driver? ☐ Me ☐ Other Driver
☐ Other: _____

IV. Conditions at Time of Accident:

1. What time of day did the accident occur?
☐ Daylight ☐ Dawn ☐ Dusk
☐ Night ☐ Other _____

2. What was the condition of the road?
☐ Dry ☐ Icy ☐ Damp ☐ Wet
☐ Snow Covered ☐ Other _____

3. Visibility:
a. What was the visibility at impact?
☐ Good ☐ Fair ☐ Poor
☐ Other _____

b. If visibility was poor, why?
☐ Sun light ☐ Darkness ☐ Rain
☐ Snow ☐ Fog ☐ Traffic
☐ Other _____

V. At Moment of Impact:

1. Were you prepared for the accident?
☐ Accident was a complete surprise
☐ Aware of impending collision
☐ And braced for impact

2. Were you wearing a seat belt?
☐ YES ☐ NO

3. Did the air bags deploy?
☐ YES ☐ NO

4. What was your body position at impact?
☐ Straight ☐ Slouched forward
☐ Don't recall ☐ Other _____
☐Rotated: ☐ Left ☐ Right

5. What direction was your body thrown?
☐ Forward/Backward ☐ Sideways
☐ Backward/Forward ☐ Across vehicle
☐ Outside vehicle ☐ Under vehicle
☐ Don't recall ☐ Other_____

VI. Result of Impact:

1. Did any of your body parts hit the following?
☐ Steering wheel _____
☐ Dashboard _____
☐ Windshield _____
☐ Right side door _____
☐ Left side door_____
☐ Armrest _____
☐ Right window _____
☐ Left window _____
☐ Headrest _____
☐ Ceiling _____
☐ Console _____
☐ Shift lever _____
☐ Front seat _____
☐ Rear view mirror _____
☐ Other _____

VII. Immediately After Accident:

1. Did you lose consciousness?
☐ YES ☐ NO ☐ Don't Know

2. How did you feel?
☐ Confused☐ Dazed☐ Dizzy
☐ Nervous☐ Weak
☐Other_____

3. Where did you immediately develop pain?

Check all that apply to you and circle right side (R) or left side (L)

☐ Head ☐ Neck ☐ Pelvis
☐ Upper/Mid Back ☐ Abdomen
☐ Chest/Rib Cage ☐ Lower Back
☐ Shoulder R L ☐ Arms R L
☐ Elbows R L ☐ Wrists R L
☐ Forearms R L ☐ Hands R L
☐ Buttocks R L ☐ Hips R L
☐ Thighs R L ☐ Knees R L
☐ Legs R L ☐ Ankles R L
☐ Feet R L ☐ Other _____

4. If there were lacerations (cuts), where were they?

Check all that apply to you and circle right side (R) or left side (L)

☐ Head ☐ Neck ☐ Pelvis
☐ Upper/Mid Back ☐ Abdomen
☐ Chest/Rib Cage ☐ Lower Back
☐ Shoulder R L ☐ Arms R L
☐ Elbows R L ☐ Wrists R L
☐ Forearms R L ☐ Hands R L
☐ Buttocks R L ☐ Hips R L
☐ Thighs R L ☐ Knees R L
☐ Legs R L ☐ Ankles R L
☐ Feet R L ☐ Other _____

5. Describe any other significant injury?

_____
_____

6. Emergency Care at Accident/Injury Site:

a. Did you receive emergency care?
☐ YES ☐ NO

b. What type of emergency care did you receive?
☐ Bandages ☐ Splint ☐ Brace ☐ Neck Collar
☐ Other_____

7. Destination after Accident/Injury:

a. Where did you go?
☐ Hospital ☐ Home ☐ Work
☐ School ☐ Other_____

b. By whom were you driven?
☐ Myself ☐ Ambulance ☐ Friend
☐ Family Member ☐ Other _____

8. If you went to the hospital:

When did you go: _____
Hospital Name: _____
Examined by Dr._____

9. What was performed at the hospital?

_____
_____

10. What treatment administered at the hospital?

☐ Oral Medication ☐ Topical Antiseptics
☐ Injection ☐ Bandages ☐ Sutures
☐ Ice Pack ☐ Hot Pack ☐ Splint
☐ Cast ☐ Brace ☐ Collar
☐ Support ☐ Surgery ☐ Other ___

11. Instructions given when discharged from hospital?

a. Were told to see?
☐ General Practitioner ☐ Chiropractor
☐ Physical Therapist ☐ Orthopedist
☐ General Surgeon ☐ Neurologist
☐ Plastic Surgeon ☐ Internist
☐ Other _____

b. What recommendations were made?
☐ No further care ☐ Heat ☐ Collar
☐ No follow-up instructions ☐ Rest
☐ Observation ☐ Support ☐ Ice
☐ Time off work ☐ Other_____

c. Were medications prescribed?
☐Pain ☐ Anti-inflammatory
☐ Antibiotic ☐ Nervousness
☐ Other _____

12. Since your accident have you suffered from?
☐ Blurred Vision ☐ Chest Pain
☐ Nausea ☐ Palpitations
☐ Double Vision ☐ Difficulty breathing
☐ Vomiting ☐ Reduced Vision
☐ Constipation ☐ Impaired Hearing
☐ Inability to hold urine
☐ Frequent Urination
☐ Ringing in ears ☐ Painful Urination
☐ Anxiety ☐ Convulsions
☐ Restlessness ☐ Diarrhea
☐ Depression ☐ Dizziness
☐ Insomnia ☐ Headaches
☐ Mood swings ☐ Light Sensitivity
☐ Nervousness ☐ Reduced Appetite
☐ Fainting ☐ Loss of Balance
☐ Poor Memory ☐ Weakness
☐ Tension ☐ Fatigue
☐ Weight Gain ☐ Weight Loss
☐ Other _____

13. Are you restricted in any areas as result of this accident?
☐ Daily Living ☐Occupational/Work
☐ Recreational Activities
☐ Other _____

14. Have you missed work due to this accident?
☐ NO
☐NO, but limited work activity
☐ YES, From ____/____/____ to ____/____/____

15. Did you self treat your symptoms?
☐ Ice ☐ Heat ☐ Bed Rest
☐ Over-the-counter Medications ☐ Other____

16. Have you gotten medical treatment elsewhere?
☐ NO ☐ YES, explain
_____

If a police report was issued, please let the front desk know so we can make a copy for our records.

Please fill out the following page regarding Claim and Attorney Information.

By Signing below, I hereby certify that the above information is complete and accurate to the best of my knowledge.

Patient Signature		Date	

VII. Insurance/Attorney Information:

1. Have you contacted an insurance adjuster or representative regarding this claim?

From YOUR Insurance-
Company: _____
Adjuster's Name: _____
Phone Number: _____
Claim #: _____

From THE OTHER DRIVER'S Insurance-
Company: _____
Adjuster's Name: _____
Phone Number: _____
Claim #: _____

2. Have you engaged services of an attorney?
Per our office policy, if your claim is a Third Party (meaning you do not have any benefits on your insurance policy that will pay for your claim) we require that an attorney represent you for your protection as well as ours.

Office Name: _____
Attorney/Paralegal Handling Case: _____
Address: _____
City, State ZIP: _____
Phone: _____

I disclose all pertinent medical information to the above parties for payment on this claim. I hereby authorize, 360 Chiropractic, to retain any necessary information from the above parties to assist in the settling of this claim.

Patient Signature		Date	