

AUTO COLLISION QUESTIONNAIRE I

Patient _____ Date _____

Please explain in detail how your accident happened: _____

State auto collision occurred in: KY OH Other _____

Driver of vehicle you were injured in: Self _____

Driver's Car Insurance: _____

Policy# _____ Claim# _____

Name of person/adjustor who has contacted you: _____

Driver of vehicle that hit you: None _____

At Fault Car Insurance: _____

Policy# _____ Claim# _____

Name of person/adjustor who has contacted you: _____

Have you retained an attorney? No Yes Not Yet

If so, name, address & phone _____

Date and time of accident: _____ am pm # of people in your vehicle: _____

Were you the: Driver Front Passenger Rear Passenger Other _____

Were the police notified? Yes No Was there a police report filed? Yes No

Did your vehicle strike another vehicle involved? Yes No Other _____

Did other vehicle(s) strike your vehicle? Yes No Other _____

Impact to your vehicle was on: Front Rear Driver Side Passenger Side Rooftop
 Front Right corner Front Left corner Rear Right corner Rear Left Corner

Compared to my vehicle, the other vehicle was: Bigger Smaller Same size

The collision moved my vehicle: A little More than a little A lot

The amount of damage to my vehicle was: A little More than a little A lot

Road conditions were: Dry Wet Ice/snow Dirt Gravel Other _____

Did airbag employ? Yes No Were you injured by the airbag? Yes No

Did head strike windshield or object? Yes No Were you knocked unconscious? No Yes, how long _____

Direction you were looking when accident occurred? Straight ahead Down Up Turned Right Turned Left
Other _____

Top of headrest was located... Above Center Below Unknown ... to top of your head.

The distance between my head & the headrest was: less than 1 inch 1-2 inches greater than 2 inches Unknown

My seat was: Not tilted back Tilted back a little Tilted back more than a little

AUTO COLLISION QUESTIONNAIRE II

Patient _____ Date _____

Type of restraints used? Shoulder & lap Lap only None used

Were bruises or injuries received as a result of the seat belt? Yes No

Location: Stomach Breast Shoulder Other _____

Were you surprised by the accident? Yes No

At the time of the collision my body hit: Nothing Windshield Steering wheel Ceiling Door

Dashboard Another body Other _____

Articles inside the vehicle that moved because of the collision: Nothing Glasses Drink Purse Papers

Other _____

At the time of the collision this part of my body struck something: Head Lt shoulder Rt shoulder Lt arm/hand

Rt arm/hand Lt hip/leg Rt hip/leg Lt knee Rt knee Lt foot Rt foot

Other _____

At the time of the collision my hands were on: Steering wheel Stickshift Other _____

At the time of collision my feet were on the: Brake Gas Clutch Floor Other _____

Did you feel pain immediately after the collision? Yes No, Later that day Next day Other _____

Where did you feel pain immediately after collision? _____

Where were you taken after accident? _____

Was any Doctor consulted after accident? No Yes, Dr. _____

Doctor's diagnosis: _____

Treatment given: _____

How often did you see the doctor? (1 time, 2X/wk, etc.) _____

How long did you see the doctor? (# days, weeks or months) _____

Have you ever had any complaints to involved area before? No Yes, what were the complaints _____

Because of this automobile collision I have seen: No one ER Medical Doctor Another Chiropractor

Physical Therapist Massage Therapist Other _____

Because of this accident I am: Taking medication Taking NO medication

Were there any broken bones as a result of this accident? Yes No

If yes, what _____

Have you lost any days from work due to this accident? Yes No

If yes, list dates _____

Before this injury, were you capable of working on an equal basis with others your age? Yes No

Are your work activities restricted as a result of this accident? No Yes, list _____

Have you had any accidents or trauma since this automobile collision? Yes No

If yes, list _____

Since this injury, your symptoms have: Improved Gotten Worse Remained the Same

Patient Signature _____ Date _____