New Dimensions Chiropractic Center

Auto Accident Questionnaire

1. What was the date of the accident?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. What time did the accident occur?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. How many vehicles were involved in the accident?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. What was the estimated damage to the vehicle you were in? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. What state did the accident occur in? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6. What city did the accident occur in? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

7. What street or intersection were you on when the accident occured? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

8. What direction were you traveling in? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

9. What type of impact was the auto accident? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

10. Did your vehicle hit anything after the accident? if yes, please describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

11. Where were you sitting in the vehicle during the accident? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

12. Did you know the accident was coming?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

13. What type of vehicle were you in? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

14. What type of vehicle impacted yours? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

15. At the time of the impact, how fast was your vehicle moving? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

16. At the time of impact, how fast was the other vehicle moving? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

17. During and after the crash what happened to your vehicle? (circle all that apply)

- kept going straight - spun around

- kept going straight hitting a car in front - spun around and hit a stationary object

- was hit by another vehicle - hit a stationary object

18. Did you lose consciousness during the accident? -yes - no

19. How was your head positioned during the accident? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

20. How was your torso positioned during the accident? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

21. How were your hands positioned during the accident? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

22. Did your head hit anything during the accident? -no - yes, please describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_

23. Did your face hit anything during the accident? -no - yes, please describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

24. Did your shoulders hit anything during the accident? -no - yes, please describe\_\_\_\_\_\_\_\_\_\_

25. Did your neck hit anything during the accident? -no - yes, please describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_

26. Did your chest hit anything during the accident? -no - yes, please describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_

27. Did your hips hit anything during the accident? -no - yes, please describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

28. Did your knees hit anything during the accident? -no - yes, please describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_

29. Did your feet hit anything during the accident? -no - yes, please describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

30. What kind of headrest was in your vehicle?

- movable fixed headrest

- nonmovable fixed headrest

- no headrest

31. Where was the headrest positioned on your head? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

32. Did you have your seatbelt on during the accident? - yes -no

33. Did you slide out of your seatbelt during the accident? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

34. What was damaged in your vehicle? (Circle all that apply)

- windshield - rear bumper - mirror

- steering wheel - front bumper - knee bolster

- dashboard - trunk - back right door

- seat frame - front left door - completely totalled

- side window - front right door

- rear window - back left door

35. Choose the items that dented inward

- floorboards - side door - dashboard

36. Choose the doors that would not open as a result of the accident

- front left - front right

- rear left - rear right

37. Did you go to the hospital? If no, why and do not answer 38-43 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

38. How did get to the hospital? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

39. What was the name of the hospital? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

40. Were you hospitalized over night? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

41. Circle what you were prescribed at the hospital

- pain medication - muscle relaxors - neck brace

42. Did you recieve any stitches for any cuts at the hospital? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

43. Were x rays taken at the hosiptal? If yes, which area was taken? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_