

Spine & Injury Clinic of Laramie, PC

AUTOMOBILE ACCIDENT QUESTIONNAIRE

Patient's Name: _____

Today's Date: _____

Date of Accident: _____

Time of Accident _____

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

Vehicle type:

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

Vehicle size:

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

Your position in the vehicle:

- Driver
- Passenger ----- Location-----
- Other _____
- Left
- Middle
- Right
- Front Passenger
- Rear Passenger
- Third Seat (rear)

Speed of your vehicle:

- Stopped
- Parked
- Slowing
- Moving Moderately
- Moving Fast
- Moving Slowly

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

Vehicle size:

- Subcompact
- Compact
- Heavy
- Full-size
- Mini
- Bus
- Mid-size
- Light
- Other _____

CONDITIONS AT THE TIME OF THE ACCIDENT:

Time of day:

- Full daylight
- Dawn
- 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

Position of YOUR head at time of impact?

- Facing straight ahead
- Tilted forward
- Rotated to the left
- Rotated to the right

Position of Your body at time of impact?

- Straight
- Tilted forward
- Rotated to the left
- Rotated to the right

Damage to vehicle YOU were in:

- Incurred minimal damage
- Incurred moderate damage
- Incurred severe damage
- Was totalled
- Not known

What position was YOUR headrest in?

- High position
- Middle position
- Low position

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

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

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?

- 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

Next day discomfort...? accident?

- increased decreased same

Did your major complaints exist before the

- Yes No

In what areas did you IMMEDIATELY feel pain?

- | | | | | | | |
|-------------------------------------|----------|-------------------------------|--------------------------------|-------|-------------------------------|--------------------------------|
| <input type="checkbox"/> Head | Shoulder | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Hip | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Neck | Arm | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Thigh | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Upper back | Elbow | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Knee | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Mid back | Wrist | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Calf | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Ribs | Hand | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Ankle | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Chest | Fingers | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Foot | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Abdomen | Buttock | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Toes | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Low Back | | | | | | |
| <input type="checkbox"/> Pelvis | | | | | | |

In what areas did you experience lacerations (cuts)?

- | | | | | | | |
|-------------------------------------|----------|-------------------------------|--------------------------------|-------|-------------------------------|--------------------------------|
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| <input type="checkbox"/> Pelvis | | | | | | |

At the hospital, what areas were x-rayed?

- | | | | | | | |
|-------------------------------------|----------|-------------------------------|--------------------------------|-------|-------------------------------|--------------------------------|
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| <input type="checkbox"/> Low Back | | | | | | |
| <input type="checkbox"/> Pelvis | | | | | | |

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

- | | | | | | | |
|-------------------------------------|----------|-------------------------------|--------------------------------|-------|-------------------------------|--------------------------------|
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Patient's Signature: _____