AUTOMOBILE ACCIDENT QUESTIONNAIRE

Glenn E. Izor, D.C.

Name _____ **Today's Date** _____

Date of accident: _____ **Time of day**: _____ □ am □ pm

Road conditions: □ dry □ wet □ icy □ snowy □ gravel □ pavement □ other _____

Weather conditions: □ sunny □ cloudy □ rainy □ foggy □ snowy □ dark □ other _____

Were you: □ driver □ passenger (□ front seat □ rear seat)

Type of your vehicle: _____ **Type of other vehicle**: _____

Were you wearing seatbelt? □ yes □ no **Position of headrests**: □ raised □ lowered □ high back □ none

Did your vehicle have an airbag? □ yes □ no **If yes, did it deploy?** □ yes □ no

Direction you were headed: □ north □ south □ east □ west **On what street?** _____

Nearest know intersection: _____

Direction other vehicle headed: □ north □ south □ east □ west **On what street?** _____

Impact occurred on the: □ front □ rear □ driver's side □ passenger side

Were you aware the accident was about to happen? □ yes □ no **Did you brace yourself?** □ yes □ no

Where were you looking at time of impact? □ forward □ up □ down □ right □ left □ do not remember

Approximate speed of your vehicle: _____ mph **Other vehicle (est.)**: _____mph

Were you knocked unconscious? □ yes □ no **If so, approx. for how long?** _____

Were the police notified? □ yes □ no **Estimated damage to your vehicle**: _____

In your own words, please describe the accident: _____

_____

Please describe how you felt:

Immediately after the accident: _____

Hours or days later: _____

What are your present complaints/symptoms? _____

Were you taken to the emergency room? □ yes □ no **If so, what treatment was done in the ER?** _____

_____

Have you been treated by any other doctor for this accident? □ yes □ no **If yes, please list his/her name and address**: _____

What treatment was given? _____

Are you taking medications because of this accident? □ yes □ no **If yes, what and how much are you taking?**

_____

Since this injury, are your symptoms: □ improving □ about the same □ getting worse

Have you lost time from work due to this accident? □ yes □ no **How much time?** _____

Have you ever been injured in an automobile accident before this one? □ yes □ no **If yes, please list when it occurred and what injuries you had**: _____

Were you having any of the above listed symptoms prior to the accident? □ yes □ no

Have you noticed any activity restrictions as a result of this injury? □ yes □ no **If yes, please describe**:

_____

_____ _____

PATIENT'S SIGNATURE **DATE**