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 occurred? _____

8. What direction were you traveling in? ☐ North ☐ South ☐ East ☐ West

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
- ☐ No movable fixed headrest
- ☐ No headrest

31. Where was the headrest positioned on your head? _____

32. Did you have your seatbelt on during the accident? ☐ No ☐ Yes

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

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

☐ **Completely totaled**

- ☐ Windshield
- ☐ Steering wheel
- ☐ Dashboard
- ☐ Seat frame
- ☐ Side window
- ☐ Rear bumper
- ☐ Front bumper
- ☐ Trunk
- ☐ Knee bolsters
- ☐ Mirror
- ☐ Front left door
- ☐ Front right door
- ☐ Back left door
- ☐ Back right door
- ☐ Rear window
- ☐ Other: _____

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? ☐ No ☐ Yes
If no, why not (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 Relaxers ☐ Neck Brace

42. Did you receive any stitches for any cuts at the hospital? _____

43. Were X-Rays taken at the hospital? ☐ No ☐ Yes
If yes, which area was taken? _____