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AUTO COLLISION QUESTIONNAIRE

Patient Name: ____ Today's Date: ____________

Date of Collision: ____________________ Time of Collision: _____: _____ ☐ AM ☐ PM

Location of Collision: ____

Were you: Driver / Passenger (circle one)

Were you wearing a seat belt? ☐ Yes ☐ No
With a shoulder harness? ☐ Yes ☐ No

Your car: ________________________________
Year Make Model

Other Car: ________________________________
Year Make Model

☐ Front impact ☐ Side impact ☐ Rear impact ☐ Non-collision: __________________________

Describe what happened to your body upon impact: ____

____

Estimated speed of **your** car: ___________ mph ☐ Speeding up ☐ Braking ☐ Totally stopped

Estimated speed of **other** car: ___________ mph ☐ Speeding up ☐ Braking ☐ Totally stopped

Did you brace for impact? ☐ Yes ☐ No Was your foot on the brake: ☐ Yes ☐ No

Describe your body position at impact? ☐ head forward ☐ head turned left ☐ head turned right
☐ body forward ☐ body turned left ☐ body turned right
☐ other: ____

Did any part of your body strike the inside of the car? ☐ No ☐ Yes: __________________________

Any cuts, bruises or abrasions? ☐ No ☐ Yes: ____

Hit your head or lose consciousness? ☐ No ☐ Yes: ____

Were the police summoned? ☐ No ☐ Yes Was an ambulance summoned? ☐ No ☐ Yes
Did you go to the hospital? ☐ No ☐ Yes Were x-rays taken? ☐ No ☐ Yes

Have you been examined and/or treated for your injuries? ☐ No ☐ Yes (please describe):

____

____

Circle all that apply: Emergency room / X-rays / CT / MRI / Pain Medication / Muscle Relaxers / NSAIDS

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QUESTIONNAIRE PAGE 2

Patient Name: ____ Today's Date: ___________

How did you feel immediately after the collision? ____

____

Could you move all parts of your body? ☐ Yes ☐ No: ____________________________________

Could you exit the car and walk unaided? ☐ Yes ☐ No: ____________________________________

How did you feel **that night**? ____

____

How did you feel over the **next few days**? ____

____

Check any symptoms that have occurred since the collision:

- ☐ headache
- ☐ neck pain/stiffness
- ☐ mid back pain
- ☐ low back pain
- ☐ dizziness
- ☐ numbness (arms/hands)
- ☐ shortness of breath
- ☐ numbness (legs/feet)
- ☐ fatigue
- ☐ sleeping problems
- ☐ nervous/anxious
- ☐ tension
- ☐ Other: ____

Have you missed time for work? ☐ No ☐ Yes : missed full time work: from _________ to _________

missed part time work: from _________ to _________

Are your work activities restricted as a result of this injury? ☐ No ☐ Yes: _______________________

____

Did you have any physical complaints just before the collision? ☐ No ☐ Yes: ____________________

____

Check any symptoms that you had ***BEFORE*** the collision:

- ☐ headache
- ☐ neck pain/stiffness
- ☐ mid back pain
- ☐ low back pain
- ☐ dizziness
- ☐ numbness (arms/hands)
- ☐ shortness of breath
- ☐ numbness (legs/feet)
- ☐ fatigue
- ☐ sleeping problems
- ☐ nervous/anxious
- ☐ tension
- ☐ Other: ____

____

Patient/Guardian Signature: ____ Date: ____________