AUTO ACCIDENT QUESTIONNAIRE

Today's Date: _____

Please fill out the answers to the following questions to the best of your ability. If you have difficulty with any questions or are unsure of how best to answer, please discuss those questions with the doctor before answering. Thank you! Chiropractic Professional Center.

Last Name: _____ First Name: _____
Age: _____ Weight: _____ Height: _____
Are you: ( ) Married ( ) Single ( ) Divorced ( ) Separated ( ) Widowed ( ) Living with a significant other
Are you a parent? NO Yes, with 1 2 3 4 5 6 Children
Occupation: _____ For how long: ____ years, _____ months
Make and model of the vehicle you were in _____ Year _____
Date of Accident (___/____/_____) Which state did the accident take place in? _____

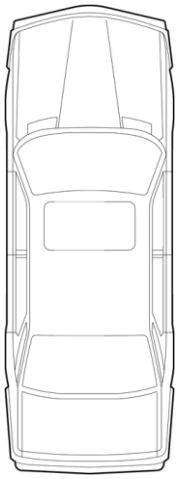
(Check one for each question)

You were:
___ the driver
___ front seat passenger
___ rear seat passenger

Your vehicle was struck:
___ in the rear
___ in the right rear
___ in the left rear
___ in the driver's side
___ in the passenger's side
___ in the front
___ in the right front
___ in the left front
(other) explain below

Your vehicle was struck by:
___ a car
___ a van
___ a pickup truck
___ a bus
___ another vehicle(what type) _____

Draw an arrow to show where you were hit



Your vehicle was:
__ stopped at a traffic light
__ stopped at a stop sign
__ stopped for a pedestrian
__ stopped in traffic
__ at a complete stop
__ slowing down for a traffic signal
__ slowing down for a stop sign
__ slowing down for pedestrian
__ slowing down to traffic
__ slowing down to turn
__ slowing down to park
__ making a right-hand turn
__ making a left-hand turn
__ moving with the flow of traffic
(other) explain below

Damage to your vehicle was
a) none or almost
b) minimal (below 1,000)
c) significant (above 1,000)
d) extensive (3,000 or more)

Damage you the other vehicle was
a) none or almost
b) minimal (below 1,000)
c) significant (above 1,000)
d) extensive (3,000 or more)

Will a photo of the damage represent the severity of the impact very well? YES or NO

Additional information on collision (if the information given already doesn't describe the accident fully)

_____

_____

Please continue on reverse side

Have you had any accidents or injuries since this accident? NO, If yes, please explain..

_____
_____
_____
_____

Please answer the following questions.

1) Since the accident, is there anything you have been unable to do? _____
_____

2) Since the accident, is there anything you have had difficulty doing? _____
_____

3) Since the accident have you been able to continue with most of your daily activities? _____
_____

Please answer the following questions.

(Please circle your answer)

Were you wearing your seatbelt? **YES or NO**
Did your airbags deploy and hit you? **YES or NO**
Were you: **Sitting squarely in your seat; Twisted in your seat; Leaning forward; Leaning on your side**
Was your head positioned: **Face-forward; Turned to the left; Turned to the right; Unsure**
Were you aware of the impending collision? **YES or NO** Braced for impact? **YES or NO**
Was your head and body thrown backward and forward in a forceful manner? **YES or NO**
Was your head and body thrown from one side to the other in a forceful manner? **YES or NO**
Did the shoulder restraint of your seatbelt prevent you from hitting the steering wheel? **YES or NO**
Did you hit your head on the **steering wheel**, **windshield**, **visor**, **roof**, **side window**, **headrest**?
Other: _____

Place marks to answer:

Did you go:
___ immediately to the hospital by ambulance
___ to the hospital after the accident using your own transportation
___ to the hospital, but some days later. If so when (___/___/_____)
___ to a private physician. If so when (___/___/_____)

Name of the hospital or Doctor? _____
(Request Records)