

# 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.

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 \_\_\_\_\_

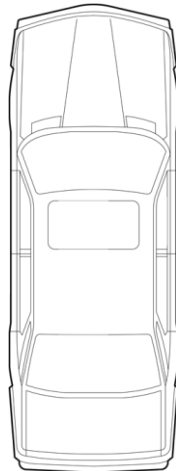
Date of Accident ( \_\_\_/\_\_\_/\_\_\_ ) Which state did the accident take place in? \_\_\_\_\_

(Check one for each question)

### You were:

- \_\_\_ the driver
- \_\_\_ front seat passenger
- \_\_\_ rear seat passenger

**Draw an arrow to  
show where you  
were hit**



### 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) \_\_\_\_\_

### 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..**

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**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)

**Dr.Inital: \_\_\_\_\_**