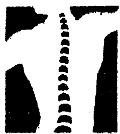

NORTH SUBURBAN FAMILY CHIROPRACTIC

Automobile Accident Questionnaire

VEHICLE YOU WERE IN

VEHICLE TYPE?
❑ Car ❑ Pickup
❑ Van ❑ Truck
❑ Station Wagon ❑ Bus
Other

VEHICLE SIZE?
❑ Subcompact ❑ Full-size
❑ Compact ❑ Mini
❑ Mid-size ❑ Light
Other

WHAT WAS YOUR LOCATION IN THE VEHICLE
❑ Driver ❑ Front Passenger ❑ Rear Passenger
Passenger Location ❑ Left ❑ Middle ❑ Front
Other

WHAT WAS THE VEHICLE YOU WERE IN DOING?

Was your vehicle stopped for?
❑ Traffic Light ❑ Intersection ❑ Stop Sign
❑ Pedestrian ❑ Parked ❑ Traffic
Other

WAS YOUR VEHICLE SLOWING DOWN FOR?
❑ Traffic Light ❑ Intersection ❑ Stop Sign
❑ Pedestrian ❑ Turning ❑ Traffic
Other

WAS YOU VEHICLE MOVING?
❑ Slowly ❑ Moderately ❑ Fast
❑ ______ MPH ❑ Accelerating

WHAT DAMAGE DID THE VEHICLE YOU WERE IN SUSTAIN?
❑ Minimal ❑ Moderate ❑ Extensive
❑ Unsure ❑ Totaled ❑ Other
Other

IF OTHER VEHICLES INVOLVED IN ACCIDENT

FIRST VEHICLE TO STRIKE VEHICLE YOU WERE IN

VEHICLE TYPE?
❑ Car ❑ Pickup
❑ Van ❑ Truck
❑ Station Wagon ❑ Bus
Other

VEHICLE SIZE?
❑ Subcompact ❑ Full-size
❑ Compact ❑ Mini
❑ Mid-size ❑ Light
Other

HOW DID THIS VEHICLE STRIKE THE VEHICLE YOU WERE IN?
❑ Head On ❑ From Right ❑ From Left
❑ Rear Ended ❑ Sideswiped on right ❑ Sideswiped on left
Other

WHAT DAMAGE DID THIS VEHICLE SUSTAIN?
❑ Minimal ❑ Moderate ❑ Extensive
❑ Unsure ❑ Totaled ❑ Other ________
Other

SECOND VEHICLE TO STRIKE VEHICLE YOU WERE IN

VEHICLE TYPE?
❑ Car ❑ Pickup
❑ Van ❑ Truck
❑ Station Wagon ❑ Bus
Other

VEHICLE SIZE?
❑ Subcompact ❑ Full-size
❑ Compact ❑ Mini
❑ Mid-size ❑ Light
Other

HOW DID THIS VEHICLE STRIKE THE VEHICLE YOU WERE IN?
❑ Head On ❑ From Right ❑ From Left
❑ Rear Ended ❑ Sideswiped on right ❑ Sideswiped on left
Other

WHAT DAMAGE DID THIS VEHICLE SUSTAIN?
❑ Minimal ❑ Moderate ❑ Extensive
❑ Unsure ❑ Totaled ❑ Other
Other

DESCRIBE OTHER VEHICLES TO STRIKE YOUR VEHICLE
Vehicle Type: How it struck:
Vehicle Size: Damage:

WERE TRAFFIC CITATIONS ISSUED AS A RESULT OF THE ACCIDENT?
❑ No citations issued ❑ Driver of other vehicle
❑ Driver of vehicle you were in ❑ You ❑Unsure

CONDITIONS AT TIME OF ACCIDENT

WHAT TIME OF DAY DID THE ACCIDENT OCCUR?
❑ Daylight ❑ Dawn ❑ Dusk ❑ Night
❑ Other

WHAT WAS THE CONDITION OF THE ROAD?
❑ Dry ❑ Damp ❑ Wet ❑ Snowy
❑ Icy ❑ Other

WHAT WAS THE VISIBILITY AT IMPACT?
❑ Good ❑ Fair ❑ Poor ❑ Other

IF VISIBILITY WAS POOR, WHY?
❑ Sun Light ❑ Darkness ❑ Rain ❑ Snow
❑ Fog ❑ Traffic ❑ Other

AT MOMENT OF IMPACT

WERE YOU PREPARED FOR THE ACCIDENT?
❑ Accident a complete surprise
❑ Aware of impending collision ❑ And braces for impact

FOOT ON BRAKE PEDAL
Was your foot on brake pedal at impact? ❑Yes ❑No
Was it knocked off pedal by impact? ❑Yes ❑No

USE OF RESTRAINTS
Were you wearing a restraint belt? ❑Yes ❑No
What type of restraint belt were you wearing? ❑Yes ❑No
❑ Shoulder-Lap Belt ❑ Shoulder Belt ❑ Lap Belt

Was vehicle equipped with headrests? ❑Yes ❑No
What position was the headrest in?
❑ Low ❑ Middle ❑ High ❑ Don't know

Was vehicle equipped with airbags? ❑Yes ❑No
Did the airbags deploy? ❑Yes ❑No

CONTINUED ON OPPOSITE SIDE

Accident / Injury Questionnaire

IMMEDIATELY AFTER ACCIDENT / INJURY

DID YOU LOSE CONSCIOUSNESS?
❑ Yes ❑ No ❑ Don`t know

HOW DID YOU FEEL?
❑ Confused ❑ Dazed ❑ Dizzy ❑ Nervous
❑ Weak ❑ Other

WHERE DID YOU IMMEDIATELY DEVELOP PAIN?
❑ Head ❑ Shoulders ❑ Buttocks
❑ Neck ❑ Arms ❑ Hips
❑ Upper/Mid Back ❑ Elbows ❑ Thighs
❑ Lower Back ❑ Forearms ❑ Knees
❑ Pelvis ❑ Wrists ❑ Legs
❑ Chest/Rib cage ❑ Hands ❑ Ankles
❑ Abdomen ❑ Feet
❑ Other

IF THERE WERE CUTS, WHERE WERE THEY?

DESCRIBE ANY OTHER SIGNIFICANT INJURY:

EMERGENCY CARE AT ACCIDENT / INJURY SITE
DID YOU RECEIVE EMERGENCY CARE? ❑YES ❑NO

WHAT TYPE OF EMERGENCY CARE DID YOU RECEIVE?
❑ Bandages ❑ Splints ❑ Brace ❑ Neck Collar
❑ Other

DESTINATION AFTER ACCIDENT / INJURY

Where did you go?
❑ Hospital ❑ Home
❑ School ❑ Work
❑ Other

By whom were you driven?
❑ Myself ❑ Ambulance
❑ Friend ❑ Family
❑ Other

HOSPITAL VISIT AFTER ACCIDENT / INJURY

WHEN DID YOU GO TO THE HOSPITAL?
❑Immediately ❑Later that day ❑Next day ❑Days later
❑ Date ____/____/____ ❑ Other

HOSPITAL NAME: **EXAMINED BY DOCTOR:**

Admitted: ❑Yes ❑No Date released ____/____/____

IF X-RAYS WERE TAKEN, OF WHAT BODY PART(S)?

IF A CAT SCAN WAS PERFORMED, OF WHAT BODY PART(S)?

IF AN MRI WAS PERFORMED, OF WHAT BODY PART(S)?

WHAT TREATMENT WAS ADMINISTERED AT THE HOSPITAL?
❑Medication ❑Sutures ❑Splint ❑Collar
❑Injection ❑Ice packs ❑Cast ❑Support
❑Antiseptics ❑Hot Packs ❑Brace ❑Surgery
❑Bandages ❑Other

INSTRUCTIONS GIVEN WHEN DISCHARGED FROM HOSPITAL
WERE YOU TOLD TO SEE
❑General practitioner ❑Chiropractor ❑Neurologist
❑Physical Therapist ❑Orthopedist ❑Internist
❑General Surgeon ❑Plastic Surgeon
❑Other

WHAT RECOMMENDATIONS WERE MADE?
❑ No further care ❑ No follow-up care ❑ Observation
❑ Rest ❑ Heat ❑ Ice
❑ Support ❑ Time off work ❑ Collar

WERE MEDICATION PRESCRIBED?
❑ Pain ❑ Anti-inflammatory ❑ Antibiotic ❑ Nervousness
❑ Other

FOLLOWING THE ACCIDENT / INJURY

HOW MUCH LATER DID ADDITIONAL SYMPTOMS DEVELOP?
❑ Immediately ❑ Hours ❑ That evening ❑ Next morning
❑ Days ❑ Week ❑ Month ❑

WHAT ADDITIONAL SYMPTOMS DEVELOPED?

SINCE YOUR ACCIDENT/INJURY HAVE YOU SUFFERED FROM?
❑ Blurred vision ❑ Chest pain ❑ Nausea
❑ Double vision ❑ Labored breathing ❑ Vomiting
❑ Reduced vision ❑ Palpitations ❑ Frequent urination
❑ Impaired hearing ❑ Constipation ❑ Painful urination
❑ Ringing in ears ❑ Diarrhea ❑ Restlessness
❑ Anxiety ❑ Convulsions ❑ Insomnia
❑ Depression ❑ Dizziness ❑ Light sensitivity
❑ Mood swings ❑ Headaches ❑ Reduced appetite
❑ Nervousness ❑ Fainting ❑ Weakness
❑ Poor memory ❑ Loss of balance ❑ Weight gain
❑ Tension ❑ Fatigue ❑ Weight loss

ARE YOU RESTRICTED IN ANY OF THE FOLLOWING AREAS AS A RESULT OF THIS ACCIDENT?
❑ Daily living ❑ Occupational ❑ Recreational
❑ Other

HAVE YOU MISSED WORK DUE TO THIS ACCIDENT/INJURY?
❑ Missed no work ❑Limited work activity
❑ Missed from: ___/___/___ to ___/___/___
❑ Other

DID YOU SELF TREAT YOUR SYMPTOMS?
❑ Ice ❑ Heat ❑ Bed rest ❑ Medication
❑ Other

DID YOU SEEK MEDICAL CARE ELSEWHERE?

General Practitioner Name:
Diagnosis and treatment:

Chiropractor Name:
Diagnosis and treatment:

Neurologist Name:
Diagnosis and treatment:

Orthopedist Name:
Diagnosis and treatment: