

# Kirk & Kirk Health Clinic, P.C.

Phone (423) 585-5556

## AUTOMOBILE ACCIDENT QUESTIONNAIRE

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Date Of Accident \_\_\_\_\_ State Accident Occurred \_\_\_\_\_

THE FOLLOWING QUESTIONS PERTAIN TO YOU AND THE VEHICLE YOU WERE IN:

**Vehicle type:**

- Car                       Pickup  
 Van                         Truck  
 Station Wagon         Bus  
 Other \_\_\_\_\_

**Vehicle size:**

- Subcompact         Full-size  
 Compact             Mini  
 Mid-size              Light  
 Heavy                 Other \_\_\_\_\_

**Your position in the vehicle:**

- Driver  
 Passenger ----- Location-----  Left             Middle             Right  
 Other \_\_\_\_\_         Front Passenger     Rear Passenger     Third Seat (rear)

**Speed of your vehicle:**

- Stopped                 Moving Moderately  
 Parked                  Moving Fast  
 Slowing                 Moving at apprx \_\_\_\_MPH  
 Moving Slowly

**Why Vehicle was slowed or stopped:**

- Traffic Signal         Parking  
 Pedestrian             Traffic  
 Stop Sign              Busy Intersection

**Collision Type:**

- Driver Side Impact         Head On Collision  
 Passenger Side Impact     Rear Impact  
 Front Impact                 Pedestrian Incident

THE FOLLOWING QUESTIONS CONCERN THE OTHER VEHICLE INVOLVED IN THE ACCIDENT:

**Vehicle type:**

- Car                       Pickup  
 Van                         Truck  
 Station Wagon         Bus  
 Other \_\_\_\_\_

**Vehicle size:**

- Subcompact         Full-size  
 Compact             Mini  
 Mid-size              Light  
 Heavy                 Other \_\_\_\_\_

CONDITIONS AT THE TIME OF THE ACCIDENT:

**Time of day:**

- Full daylight  
  
 Dusk  
 Night

**Road Conditions:**

- Dry  
 Damp  
 Wet  
 Snow covered  
 Ice covered  
 Patchy Ice/Snow

**Visibility:**

- Excellent  
 Good  
 Fair  
 Poor

**Visibility compromised by:**

- Brightness  
 Darkness  
 Rain  
 Snow  
 Fog  
 Traffic

***THE FOLLOWING QUESTIONS CONCERN THE MOMENT OF IMPACT OF THE ACCIDENT:***

**Were you...**

- Totally unaware that the accident was impending
- Aware that the accident was impending
- Aware that the accident was impending and braced for it

**Restraints: (check all that apply)**

- Seat belt
- Shoulder harness
- No restraints

**If you were the driver of the vehicle, was your foot on the brake pedal?**  Yes  No  Knocked off by impact

**Was the air bag deployed?**

- Car not equipped with air bag
- Air bag deployed
- Air bag not deployed

**What position was YOUR headrest in?**

- High position
- Middle position
- Low position

**Position of YOUR head at time of impact?**

- Facing straight ahead
- Tilted forward
- Rotated to the left
- Rotated to the right

**Was your head thrown...?**

- Backward and then forward
- Forward then backward
- To the left  To the left then the right
- To the right  To the right, then the left

**Position of Your body at time of impact?**

- Straight
- Tilted forward
- Rotated to the left
- Rotated to the right

**Was your body thrown...?**

- Backward and then forward
- Forward then backward
- To the left  To the left then the right
- To the right  To the right, then the left
- Across the vehicle  Outside the vehicle
- Under the vehicle

**Damage to vehicle YOU were in:**

- Incurred minimal damage
- Incurred moderate damage
- Incurred severe damage
- Was totaled
- Not known

**Citations:**

- None issued
- Yourself
- Driver of vehicle patient was a passenger of
- Driver of other vehicle
- Not sure

***AS A RESULT OF THE FORCE OF THE COLLISION, WHICH OBJECTS IN THE VEHICLE DID YOUR BODY STRIKE?***

**Head**

- |   |                                       |
|---|---------------------------------------|
| <input type="checkbox"/> Steering wheel   | <input type="checkbox"/> Right door   |
| <input type="checkbox"/> Dashboard        | <input type="checkbox"/> Left window  |
| <input type="checkbox"/> Windshield       | <input type="checkbox"/> Right window |
| <input type="checkbox"/> Armrest          | <input type="checkbox"/> Console      |
| <input type="checkbox"/> Headrest         | <input type="checkbox"/> Gear shift   |
| <input type="checkbox"/> Rear view mirror | <input type="checkbox"/> Front seat   |
| <input type="checkbox"/> Left door        | <input type="checkbox"/> Backseat     |

**Left Arm**

- |   |                                       |
|---|---------------------------------------|
| <input type="checkbox"/> Steering wheel   | <input type="checkbox"/> Right door   |
| <input type="checkbox"/> Dashboard        | <input type="checkbox"/> Left window  |
| <input type="checkbox"/> Windshield       | <input type="checkbox"/> Right window |
| <input type="checkbox"/> Armrest          | <input type="checkbox"/> Console      |
| <input type="checkbox"/> Headrest         | <input type="checkbox"/> Gear shift   |
| <input type="checkbox"/> Rear view mirror | <input type="checkbox"/> Front seat   |
| <input type="checkbox"/> Left door        | <input type="checkbox"/> Backseat     |

**Right Arm**

- Steering wheel
- Dashboard
- Windshield
- Armrest
- Headrest
- Rear view mirror
- Left door

- Right door
- Left window
- Right window
- Console
- Gear shift
- Front seat
- Backseat

**Torso**

- Steering wheel
- Dashboard
- Windshield
- Armrest
- Headrest
- Rear view mirror
- Left door

- Right door
- Left window
- Right window
- Console
- Gear shift
- Front seat
- Backseat

**Left Leg**

- Steering wheel
- Dashboard
- Windshield
- Armrest
- Headrest
- Rear view mirror
- Left door

- Right door
- Left window
- Right window
- Console
- Gear shift
- Front seat
- Backseat

**Right Leg**

- Steering wheel
- Dashboard
- Windshield
- Armrest
- Headrest
- Rear view mirror
- Left door

- Right door
- Left window
- Right window
- Console
- Gear shift
- Front seat
- Backseat

**THE FOLLOWING QUESTIONS CONCERN THE TIME PERIOD IMMEDIATELY FOLLOWING THE ACCIDENT:**

**Did you lose consciousness?**

- Yes
- No

**Immediately following the accident, did you feel...?**

- Dizzy
- Dazed
- Disoriented
- Weak
- Nervous
- Nauseated

**Were you able to walk unaided?**

- Yes
- No

**Where did you go...?**

- Drove home
- Was driven home
- Drove to hospital
- Was driven to hospital
- Taken to hospital via ambulance
- Drove to work
- Was driven to work
- Drove to school
- Was driven to school

**Did your major complaints exist before the accident?**  Yes  No

**Next day discomfort...?**  increased  decreased  same

**In what areas did you IMMEDIATELY feel pain?**

- |                                     |          |                               |                                |       |                               |                                |
|-------------------------------------|----------|-------------------------------|--------------------------------|-------|-------------------------------|--------------------------------|
| <input type="checkbox"/> Head       | Shoulder | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Hip   | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Neck       | Arm      | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Thigh | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Upper back | Elbow    | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Knee  | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Mid back   | Wrist    | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Calf  | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Ribs       | Hand     | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Ankle | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Chest      | Fingers  | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Foot  | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Abdomen    | Buttock  | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Toes  | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Low Back   |          |                               |                                |       |                               |                                |
| <input type="checkbox"/> Pelvis     |          |                               |                                |       |                               |                                |

**In what areas did you experience lacerations (cuts)?**

- |                                     |          |                               |                                |       |                               |                                |
|-------------------------------------|----------|-------------------------------|--------------------------------|-------|-------------------------------|--------------------------------|
| <input type="checkbox"/> Head       | Shoulder | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Hip   | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Neck       | Arm      | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Thigh | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
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| <input type="checkbox"/> Low Back   |          |                               |                                |       |                               |                                |
| <input type="checkbox"/> Pelvis     |          |                               |                                |       |                               |                                |

**At the hospital, what areas were x-rayed?**

- |                                     |          |                               |                                |       |                               |                                |
|-------------------------------------|----------|-------------------------------|--------------------------------|-------|-------------------------------|--------------------------------|
| <input type="checkbox"/> Head       | Shoulder | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Hip   | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
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| <input type="checkbox"/> Chest      | Fingers  | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Foot  | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Abdomen    | Buttock  | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Toes  | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Low Back   |          |                               |                                |       |                               |                                |
| <input type="checkbox"/> Pelvis     |          |                               |                                |       |                               |                                |

**Where did you experience pain on the day FOLLOWING the accident?**

- |                                     |          |                               |                                |       |                               |                                |
|-------------------------------------|----------|-------------------------------|--------------------------------|-------|-------------------------------|--------------------------------|
| <input type="checkbox"/> Head       | Shoulder | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Hip   | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Neck       | Arm      | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Thigh | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
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| <input type="checkbox"/> Chest      | Fingers  | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Foot  | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Abdomen    | Buttock  | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Toes  | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Low Back   |          |                               |                                |       |                               |                                |
| <input type="checkbox"/> Pelvis     |          |                               |                                |       |                               |                                |

**Patient's Signature:** \_\_\_\_\_