

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

- Steering wheel
- Dashboard
- Windshield
- Armrest
- Headrest
- Rear view mirror
- Left door
- Right door
- Left window
- Right window
- Console
- Gear shift
- Front seat
- Backseat

Left Arm

- Steering wheel
- Dashboard
- Windshield
- Armrest
- Headrest
- Rear view mirror
- Left door
- Right door
- Left window
- Right window
- Console
- Gear shift
- Front seat
- 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
- Weak
- Dazed
- Nervous
- Disoriented
- Nauseated

Were you able to walk unaided?

- Yes
- No

Where did you go...?

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

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
<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
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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

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
<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
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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

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
<input type="checkbox"/> Upper back	Elbow	<input type="checkbox"/> Left	<input type="checkbox"/> Right	Knee	<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

Patient's Signature: _____