

Auto Accident Injury Questionnaire

MR# _____

Name: _____ Date of visit: _____

Date of Accident: _____

Is litigation pending? Yes No

At the time of the accident did you experience any loss of consciousness?

- Yes
 No
 No, but I was dazed and confused following the Impact

At the time of the accident I was:

- The driver A motorcycle rider
 A front seat passenger A bicyclist
 A rear seat passenger A pedestrian Other (please explain): _____

The type of collision was:

- Head-on collision Side-swiped
 Rear-ended Roll-over
 T-boned Other (please explain): _____

How many Vehicles were involved in the accident? _____

Just before impact my vehicle was (describe what your vehicle was doing, Ex. Heading East Bound on SR-60 and Kelly Road in Right Lane of a 3-Lane Highway; or Stopped at a Red light at SR-60 and):

Just before impact the other vehicle(s) was (describe what your vehicle was doing, Ex. On Kelly Road, turning right onto SR-60; or Heading West Bound on SR-60, but then in process of making a U-turn):

Were you aware of the impending crash? (Did you see it coming?) Yes No

Please check the part(s) of your vehicle that made contact with the other vehicle(s)

- | | |
|--|---|
| <input type="checkbox"/> Front Bumper | <input type="checkbox"/> Rear passenger side door |
| <input type="checkbox"/> Driver Side Front bumper | <input type="checkbox"/> Driver side rear fender |
| <input type="checkbox"/> Passenger side front bumper | <input type="checkbox"/> Passenger side rear fender |
| <input type="checkbox"/> Driver side front fender | <input type="checkbox"/> Driver side rear bumper |
| <input type="checkbox"/> Passenger side front fender | <input type="checkbox"/> Passenger side rear bumper |
| <input type="checkbox"/> Front driver's door | <input type="checkbox"/> Rear bumper |
| <input type="checkbox"/> Front Passenger's door | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Rear driver's side door | <input type="checkbox"/> Other _____ |

Please check the part(s) of the other vehicle(s) that made contact with your vehicle

- | | |
|--|---|
| <input type="checkbox"/> Front Bumper | <input type="checkbox"/> Rear passenger side door |
| <input type="checkbox"/> Driver Side Front bumper | <input type="checkbox"/> Driver side rear fender |
| <input type="checkbox"/> Passenger side front bumper | <input type="checkbox"/> Passenger side rear fender |
| <input type="checkbox"/> Driver side front fender | <input type="checkbox"/> Driver side rear bumper |
| <input type="checkbox"/> Passenger side front fender | <input type="checkbox"/> Passenger side rear bumper |
| <input type="checkbox"/> Front driver's door | <input type="checkbox"/> Rear bumper |
| <input type="checkbox"/> Front Passenger's door | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Rear driver's side door | <input type="checkbox"/> Other _____ |

What were the road conditions at the time of the impact?

- Wet Dry Icy Foggy Dark Other _____

What was your approximate speed just before impact? _____ MPH

What was the approximate speed of the other vehicle(s) just before impact? _____ MPH

What Safety Devices were utilized at the Time of Impact?

- | | |
|---|---|
| <input type="checkbox"/> Restrained (wearing seat belt) | <input type="checkbox"/> Airbags deployed |
| <input type="checkbox"/> Unrestrained (not wearing seat belt) | <input type="checkbox"/> Airbag did not deploy |
| <input type="checkbox"/> Wearing a helmet | <input type="checkbox"/> Vehicle had no airbags |
| <input type="checkbox"/> Not wearing a helmet | <input type="checkbox"/> Other _____ |

I was restrained by:

- Lap Belt No lap belt Shoulder belt No shoulder belt

Airbags:

- Deployed
 Did not deploy
 Vehicle was not equipped with airbags

My vehicle was (TYPE OF VEHICLE – Make/Model; Example Nissan Maxima/4-Door Car; Chevy Blazer/Full-Size SUV;

Include if it is a trailer, pick-up, full SUV, mid-size SUV, 18-wheeler, Van, Minivan, 4-door Car, 2-door Car, Motorcycle, Bicycle):

The other vehicle was (TYPE OF VEHICLE – Make/Model; Example Nissan Maxima/4-Door Car; Chevy Blazer/Full-Size SUV;

Include if it is a trailer, pick-up, full SUV, mid-size SUV, 18-wheeler, Van, Minivan, 4-door Car, 2-door Car, Motorcycle, Bicycle):

Were your vehicles seats broken as a result of the crash? Yes No

After the accident was your vehicle deemed a total loss? Yes No

Which of your body parts struck internal objects in the vehicle?

- | | | | |
|---------------------------------------|---|---|--|
| <input type="checkbox"/> Head | <input type="checkbox"/> Forehead | <input type="checkbox"/> Right side of head | <input type="checkbox"/> Left side of head |
| <input type="checkbox"/> Back of head | <input type="checkbox"/> Right shoulder | <input type="checkbox"/> Left shoulder | <input type="checkbox"/> Right arm |
| <input type="checkbox"/> Left arm | <input type="checkbox"/> Right elbow | <input type="checkbox"/> Left elbow | <input type="checkbox"/> Right forearm |
| <input type="checkbox"/> Left forearm | <input type="checkbox"/> Right Wrist | <input type="checkbox"/> Left Wrist | <input type="checkbox"/> Right hand |
| <input type="checkbox"/> Left hand | <input type="checkbox"/> Right hip | <input type="checkbox"/> Left hip | <input type="checkbox"/> Right thigh |
| <input type="checkbox"/> Right knee | <input type="checkbox"/> Left knee | <input type="checkbox"/> Right leg | <input type="checkbox"/> Left Leg |
| <input type="checkbox"/> Right ankle | <input type="checkbox"/> Left ankle | <input type="checkbox"/> Right foot | <input type="checkbox"/> Left foot |
| <input type="checkbox"/> Other _____ | | | |

The accident resulted in lacerations of: _____

(If None write "None" above; It is Okay to Be "None")

The accident resulted in abrasions of: _____

(If None write "None" above; It is Okay to Be "None")

The accident resulted in bruising of: _____

(If None write "None" above; It is Okay to Be "None")

After the accident there were NO (It is okay to have none of these below):

- | | | | |
|--------------------------------------|--------------------------------------|---------------------------------------|------------------------------------|
| <input type="checkbox"/> Lacerations | <input type="checkbox"/> Fractures | <input type="checkbox"/> Dislocations | <input type="checkbox"/> Abrasions |
| <input type="checkbox"/> Ecchymosis | <input type="checkbox"/> Open Wounds | | |

Immediately following the accident I experienced pain in the following body part(s); and/or the following symptom(s):

In the 1 to 48 hours after the accident I experienced pain in the following body part(s); and/or the following symptom(s):

Did you go to the hospital after the accident? Yes No

If yes, how were you transported?

- Ambulance Medical (airlift) flight Private Transportation
 Other _____

The following studies/tests were performed in the emergency room:

- X-rays CT-scan MRI Blood labs Urine tests

What medication(s) were you given in the emergency room?

- None Intravenous (I.V.) medications Oral Medications

Were you given prescription(s) or anything else at time of discharge from the Emergency Room?

- None Yes, List: _____ Cervical Collar
 Other _____

Following your Emergency Room visit when did you follow up with a doctor (Example 3 weeks Later)?

If you did not go to the Emergency Room when did you first seek medical attention (Example 5 Days after Accident)?
