

FORT BEND INJURY CLINIC, PLLC

AUTOMOBILE ACCIDENT QUESTIONNAIRE

Patient's Name: _____

Today's Date: _____

Date of Accident: _____

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 approx ____ 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
☐ Other _____

Vehicle size:

- ☐ Subcompact ☐ Full-size
☐ Compact ☐ Mini
☐ Bus ☐ Mid-size ☐ Light
☐ Heavy ☐ Other _____

CONDITIONS AT THE TIME OF THE ACCIDENT:

Time of day:

- ☐ Full daylight
☐ Dawn
☐ 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

- | | |
|---|---------------------------------------|
| <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 |

Torso

- | | |
|---|---------------------------------------|
| <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 Leg

- | | |
|---|---------------------------------------|
| <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 Leg

- | | |
|---|---------------------------------------|
| <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 |

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

Next day discomfort?

- ☐ increased ☐ decreased ☐ same

Did your major complaints exist before the accident?

- ☐ Yes ☐ No

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 |
| <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 | | | | | |

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 |
| <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 | | | | | |

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"/> Ribs | Hand | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Ankle | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
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| <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: _____ Date: _____

Guardian's Signature Authorizing Care: _____ Date: _____