



# HealthSource™

Chiropractic & Progressive Rehab™

## Auto Accident Questionnaire

Today's Date: \_\_\_\_\_ Date of Accident: \_\_\_\_\_

Patient's Name: \_\_\_\_\_  
(Last name) (First name) (M.I.)

1. Were you the only one in the car? Y or N

If not, who else was there?  
\_\_\_\_\_

### The following questions concern YOU AND THE VEHICLE YOU WERE IN:

2. **Vehicle type:**

- Motorcycle  Car  SUV  Truck  Station Wagon  Van  Bus  Semi-Truck  
 Other \_\_\_\_\_

3. **Vehicle size:**

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

4. **Your position in the vehicle:**

- Driver  Passenger  Other \_\_\_\_\_

5. **If you were the PASSENGER, what was your location in the vehicle:**

- Left  Middle  Right  Front Passenger  Rear Passenger  Third Seat (rear)

6. **Speed of your vehicle:**

- Not known  Moving Slowly  Moving at approx \_\_\_\_ MPH  
 Parked  Moving Moderately  Other \_\_\_\_\_  
 Stopped  Moving Fast

7. **Why vehicle was slowed or stopped:**

- Not Applicable  Traffic Signal  Parking  Pedestrian  Traffic  Stop Sign  
 Busy Intersection  Other \_\_\_\_\_

8. **Collision Type:**

- Driver Side Impact    Head-on Collision    Passenger Side Impact    Rear Impact  
 Front Impact    Pedestrian Incident    Other \_\_\_\_\_

**The following questions concern THE OTHER VEHICLE involved in accident:**

9. **Vehicle type:**

- Motorcycle    Car    SUV    Truck    Station Wagon    Van    Bus    Semi-Truck  
 Other \_\_\_\_\_

10. **Vehicle size:**

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

**CONDITIONS AT THE TIME OF THE ACCIDENT:**

11. **Time of day:**

- Full daylight    Dusk    Night    Other: \_\_\_\_\_

12. **Road Conditions:**

- Dry    Damp    Wet    Snow covered    Ice covered    Patchy Ice/Snow    Other  
\_\_\_\_\_

13. **Visibility:**

- Excellent    Good    Fair    Poor

14. **Visibility compromised by:**

- None    Brightness    Darkness    Rain    Snow    Fog    Traffic    Other  
\_\_\_\_\_

**The following questions concern THE MOMENT OF IMPACT of the accident:**

15. **Were you:**

- Aware that the accident was impending    Did you brace yourself for the impending accident  
 Totally unaware that the accident was impending    Other \_\_\_\_\_

16. **Was the air bag deployed?**

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

Other: \_\_\_\_\_

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

- Seat belt    Shoulder harness    No restraints    Other \_\_\_\_\_

**18. Was your foot on the brake pedal?**

- Yes    No    Knocked off by impact    I was a passenger

**19. What position was your headrest in?**

- Not Known    High position    Middle position    Low position    No Headrest

**20. Position of your head at time of impact?**

- Not Known    Facing straight ahead    Tilted forward    Rotated to the left    Rotated to the right  
 Other \_\_\_\_\_

**21. Was your head thrown?**

- |  |  |                                      |
|--|--|--------------------------------------|
| <input type="checkbox"/> Not Known                 | <input type="checkbox"/> To the left             | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Backward and then forward | <input type="checkbox"/> To the left then right  |                                      |
| <input type="checkbox"/> Forward then backward     | <input type="checkbox"/> To the right            |                                      |
|  | <input type="checkbox"/> To the right, then left |                                      |

**22. Position of your body at time of impact?**

- |                                    |   |   |
|------------------------------------|---|---|
| <input type="checkbox"/> Not Known | <input type="checkbox"/> Rotated to the right | <input type="checkbox"/> Tilted forward |
| <input type="checkbox"/> Straight  | <input type="checkbox"/> Rotated to the left  | <input type="checkbox"/> Other _____    |

**23. Was your body thrown?**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Not Known                 | <input type="checkbox"/> To the left             | <input type="checkbox"/> Outside the vehicle |
| <input type="checkbox"/> Backward and then forward | <input type="checkbox"/> To the left then right  | <input type="checkbox"/> Under the vehicle   |
| <input type="checkbox"/> Forward then backward     | <input type="checkbox"/> To the right            | <input type="checkbox"/> Across the vehicle  |
|  | <input type="checkbox"/> To the right, then left | <input type="checkbox"/> Other _____         |

**24. Damage to vehicle that YOU were in:**

- Not known    Minimal damage    Moderate damage    Severe damage    Was totaled

**25. Damage to the OTHER vehicle:**

- Not known    Minimal damage    Moderate damage    Severe damage    Was totaled

**26. Citations: (Check all that apply)**

- None issued    Myself    Driver of other vehicle    Not sure if driver of other vehicle cited  
 Driver of vehicle I was a passenger of    Not sure if driver of vehicle I was in was cited

**As a result of the force of the collision,  
Which objects in the vehicle did your body strike?**

- 27.**
- | <u>Head</u>                               |                                       | <u>Torso</u>                              |                                       |
|---|---------------------------------------|---|---------------------------------------|
| <input type="checkbox"/> None             | <input type="checkbox"/> Left door    | <input type="checkbox"/> None             | <input type="checkbox"/> Left door    |
| <input type="checkbox"/> Steering wheel   | <input type="checkbox"/> Right door   | <input type="checkbox"/> Steering wheel   | <input type="checkbox"/> Right door   |
| <input type="checkbox"/> Dashboard        | <input type="checkbox"/> Left window  | <input type="checkbox"/> Dashboard        | <input type="checkbox"/> Left window  |
| <input type="checkbox"/> Windshield       | <input type="checkbox"/> Right window | <input type="checkbox"/> Windshield       | <input type="checkbox"/> Right window |
| <input type="checkbox"/> Armrest          | <input type="checkbox"/> Console      | <input type="checkbox"/> Armrest          | <input type="checkbox"/> Console      |
| <input type="checkbox"/> Headrest         | <input type="checkbox"/> Gear shift   | <input type="checkbox"/> Headrest         | <input type="checkbox"/> Gear shift   |
| <input type="checkbox"/> Rear view mirror | <input type="checkbox"/> Front seat   | <input type="checkbox"/> Rear view mirror | <input type="checkbox"/> Front seat   |
| <input type="checkbox"/> Ceiling          | <input type="checkbox"/> Backseat     | <input type="checkbox"/> Ceiling          | <input type="checkbox"/> Backseat     |
| <input type="checkbox"/> Other _____      |                                       | <input type="checkbox"/> Other _____      |                                       |

- 28.**
- | <u>Left Arm</u>                           |                                       | <u>Right Arm</u>                          |                                       |
|---|---------------------------------------|---|---------------------------------------|
| <input type="checkbox"/> None             | <input type="checkbox"/> Left door    | <input type="checkbox"/> None             | <input type="checkbox"/> Left door    |
| <input type="checkbox"/> Steering wheel   | <input type="checkbox"/> Right door   | <input type="checkbox"/> Steering wheel   | <input type="checkbox"/> Right door   |
| <input type="checkbox"/> Dashboard        | <input type="checkbox"/> Left window  | <input type="checkbox"/> Dashboard        | <input type="checkbox"/> Left window  |
| <input type="checkbox"/> Windshield       | <input type="checkbox"/> Right window | <input type="checkbox"/> Windshield       | <input type="checkbox"/> Right window |
| <input type="checkbox"/> Armrest          | <input type="checkbox"/> Console      | <input type="checkbox"/> Armrest          | <input type="checkbox"/> Console      |
| <input type="checkbox"/> Headrest         | <input type="checkbox"/> Gear shift   | <input type="checkbox"/> Headrest         | <input type="checkbox"/> Gear shift   |
| <input type="checkbox"/> Rear view mirror | <input type="checkbox"/> Front seat   | <input type="checkbox"/> Rear view mirror | <input type="checkbox"/> Front seat   |
| <input type="checkbox"/> Ceiling          | <input type="checkbox"/> Backseat     | <input type="checkbox"/> Ceiling          | <input type="checkbox"/> Backseat     |
| <input type="checkbox"/> Other _____      |                                       | <input type="checkbox"/> Other _____      |                                       |

- 29.**
- | <u>Left Leg</u>                           |                                       | <u>Right Leg</u>                          |                                       |
|---|---------------------------------------|---|---------------------------------------|
| <input type="checkbox"/> None             | <input type="checkbox"/> Left door    | <input type="checkbox"/> None             | <input type="checkbox"/> Left door    |
| <input type="checkbox"/> Steering wheel   | <input type="checkbox"/> Right door   | <input type="checkbox"/> Steering wheel   | <input type="checkbox"/> Right door   |
| <input type="checkbox"/> Dashboard        | <input type="checkbox"/> Left window  | <input type="checkbox"/> Dashboard        | <input type="checkbox"/> Left window  |
| <input type="checkbox"/> Windshield       | <input type="checkbox"/> Right window | <input type="checkbox"/> Windshield       | <input type="checkbox"/> Right window |
| <input type="checkbox"/> Armrest          | <input type="checkbox"/> Console      | <input type="checkbox"/> Armrest          | <input type="checkbox"/> Console      |
| <input type="checkbox"/> Headrest         | <input type="checkbox"/> Gear shift   | <input type="checkbox"/> Headrest         | <input type="checkbox"/> Gear shift   |
| <input type="checkbox"/> Rear view mirror | <input type="checkbox"/> Front seat   | <input type="checkbox"/> Rear view mirror | <input type="checkbox"/> Front seat   |

- Ceiling                       Backseat                       Ceiling                       Backseat  
 Other \_\_\_\_\_                       Other \_\_\_\_\_

**The following questions concern the time period  
Immediately following the accident:**

**30. Were you able to walk unaided?**

- Yes     No

**31. Did you lose consciousness?**

- Yes     No

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

- Dizzy     Weak     Dazed     Nervous     Driven home     Disoriented     Nauseated  
 Other \_\_\_\_\_

**33. Where did you go?**

- Drove home     Drove to work     Drove to hospital     Drove to school  
 Taken to hospital via ambulance     Other \_\_\_\_\_

**34. In what areas did you IMMEDIATELY feel pain?     No Pain**

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

**35. In what areas did you experience lacerations (cuts)?     No Lacerations**

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

**36. At the hospital, what areas were x-rayed?     I did not go to hospital     No X-Rays were taken**

- |                               |                                |   |   |
|-------------------------------|--------------------------------|---|---|
| <input type="checkbox"/> Head | <input type="checkbox"/> Ribs  | <input type="checkbox"/> Calf (Left/Right)  | <input type="checkbox"/> Wrist (Left/Right) |
| <input type="checkbox"/> Neck | <input type="checkbox"/> Chest | <input type="checkbox"/> Ankle (Left/Right) | <input type="checkbox"/> Arm (Left/Right)   |

- Upper back       Pelvis       Foot (Left/Right)       Elbow (Left/Right)
- Mid back       Hip (Left/Right)       Toes (Left/Right)       Shoulder (Left/Right)
- Low Back       Thigh (Left/Right)       Fingers (Left/Right)       Buttock (Left/Right)
- Abdomen       Knee (Left/Right)       Hand (Left/Right)
- Other \_\_\_\_\_       Name of Hospital \_\_\_\_\_

**37. Where did you experience pain on the day FOLLOWING the accident?     No Pain**

- Head       Ribs       Calf (Left/Right)       Wrist (Left/Right)
- Neck       Chest       Ankle (Left/Right)       Arm (Left/Right)
- Upper back       Pelvis       Foot (Left/Right)       Elbow (Left/Right)
- Mid back       Hip (Left/Right)       Toes (Left/Right)       Shoulder (Left/Right)
- Low Back       Thigh (Left/Right)       Fingers (Left/Right)       Buttock (Left/Right)
- Abdomen       Knee (Left/Right)       Hand (Left/Right)
- Other \_\_\_\_\_       Other \_\_\_\_\_
- Other \_\_\_\_\_       Other \_\_\_\_\_

**38. Was there any change in your NEXT day discomfort?**

- Increased     Decreased     Same

**39. Please Indicate Your Current Ability To Perform The Following Activities:**

- | U – Unable   | P - Painful | D - Difficult                                  | L – Limited | N - Normal   |
|--|-------------|--|-------------|--|
| <input type="checkbox"/> Coughing or sneezing            |             | <input type="checkbox"/> Climbing              |             | <input type="checkbox"/> Lying on side with knees bent |
| <input type="checkbox"/> Getting in/out of car           |             | <input type="checkbox"/> Kneeling              |             | <input type="checkbox"/> Gripping                      |
| <input type="checkbox"/> Bending forward to brush teeth  |             | <input type="checkbox"/> Balancing             |             | <input type="checkbox"/> Pushing                       |
| <input type="checkbox"/> Turning over in bed             |             | <input type="checkbox"/> Dressing Self         |             | <input type="checkbox"/> Pulling                       |
| <input type="checkbox"/> Walking short distances         |             | <input type="checkbox"/> Sleeping              |             | <input type="checkbox"/> Reaching                      |
| <input type="checkbox"/> Standing for more than one hour |             | <input type="checkbox"/> Stooping              |             | <input type="checkbox"/> Bending forward               |
| <input type="checkbox"/> Lying on back                   |             | <input type="checkbox"/> Lying flat on stomach |             | <input type="checkbox"/> Sexual activity               |
| <input type="checkbox"/> Sitting at a table              |             |  |             |  |

**40. Please Indicate any Additional Symptoms since the Car Accident**

- Depression/crying spells       Loss of smell       Numbness in fingers
- Muscle jerking       Loss of taste       Cold hands
- Low resistance       Loss of memory       Cold feet
- Confusion       Fatigue       Diarrhea
- Eyes sensitive to light       Tension       Constipation
- Pain behind the eyes       Shortness of breath       Chest pain

- |   |  |                                       |
|---|--|---------------------------------------|
| <input type="checkbox"/> Dizziness            | <input type="checkbox"/> Irritability      | <input type="checkbox"/> Nervousness  |
| <input type="checkbox"/> Fainting             | <input type="checkbox"/> Convulsions       | <input type="checkbox"/> Cold sweats  |
| <input type="checkbox"/> Ringing/buzzing ears | <input type="checkbox"/> Sleeping problems | <input type="checkbox"/> Anxious      |
| <input type="checkbox"/> Loss of balance      | <input type="checkbox"/> Numbness in toes  | <input type="checkbox"/> Other: _____ |

**41. Did any of the complaints listed exist before the accident?**

Yes    No   If Yes, please list \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**42. Did you experience anything else the day after the accident?**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**43. Please describe the accident in detail:**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**44. Please describe how you feel today:**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

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

**Today's Date:** \_\_\_\_\_