AUTOMOBILE ACCIDENT QUESTIONNAIRE

TurningPoint Chiropractic
2871 Main Street
East Point, Ga. 30344
404) 761-4441

Patient's Name:_____
Today's Date:_____
Date of Accident:_____

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

Your position in the vehicle:

❑Driver ❑Passenger -------- Location--------
❑Left ❑Middle ❑Right ❑Other _____
❑Front Passenger ❑Rear Passenger ❑Third Seat (rear)

Vehicle size:
❑Subcompact ❑Full-size
❑Compact ❑Mini
❑Mid-size ❑Light
❑Heavy ❑Other_____

Vehicle type:
❑Car ❑Truck ❑Other _____
❑Van ❑Bus
❑Station Wagon ❑Sport Utility
❑Pickup ❑Crossover

Speed of your vehicle:
❑Stopped ❑Moving Moderately
❑Parked ❑Moving Fast
❑Slowing ❑Moving at approx ____MPH
❑Moving Slowly ❑ Other _____

Why Vehicle was slowed or stopped:
❑Traffic Signal ❑Parking
❑Pedestrian ❑Traffic
❑Stop Sign ❑Busy Intersection
❑Other _____

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 THE ACCIDENT: ❑ ***N/A***

Vehicle size:
❑Subcompact ❑Light
❑Compact ❑Mini
❑Mid-size ❑Heavy
❑Full-size ❑Other_____

Vehicle type:
❑Car ❑Pickup
❑Van ❑Truck
❑Station Wagon ❑Bus
❑Other_____

CONDITIONS AT THE TIME OF THE ACCIDENT: ❑ ***N/A***

Time of day:
❑Full daylight
❑Dawn
❑Dusk
❑Night
❑ Other _____

Road Conditions:
❑Dry
❑Damp
❑Wet
❑Snow covered
❑Ice covered
❑Patchy Ice/Snow

Visibility:
❑Excellent
❑Good
❑Fair
❑Poor
❑Other _____

Visibility compromised by:
❑Brightness
❑Darkness
❑Rain
❑Snow
❑Fog
❑Traffic

THE FOLLOWING QUESTIONS CONCERN THE MOMENT OF IMPACT OF THE ACCIDENT: ❑ ***N/A***

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? ❑ ***N/A***
❑Car not equipped with air bag
❑Air bag deployed
❑Air bag not deployed

What position was YOUR headrest in? ❑ ***N/A***
❑High position
❑Middle position
❑ Low position

Position of YOUR head at time of impact? ❑ *N/A*

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

Was your head thrown...? ❑ *N/A*

❑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? ❑ *N/A*

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

Was your body thrown...? ❑ *N/A*

❑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: ❑ *N/A*

❑Minimal damage ❑Was totaled
❑Moderate damage ❑Not known
❑Severe damage ❑Other

Citations: ❑ *N/A*

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

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

Head ❑ *N/A*

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

Left Arm ❑ *N/A*

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

Right Arm ❑ *N/A*

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

Torso ❑ *N/A*

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

Left Leg ❑ *N/A*

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

Right Leg ❑ *N/A*

❑Steering wheel ❑Right door
❑Dashboard ❑Left window
❑Windshield ❑Right window
❑Armrest ❑Console
❑Headrest ❑Gear shift
❑Rear view mirror ❑Front seat
❑Left door ❑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 ❑ None
❑Dazed ❑Nervous ❑ Other _____
❑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 ❑Other _____

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

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

In what areas did you IMMEDIATELY feel pain? ❑ ***N/A***

❑Head	Shoulder	❑Left	❑Right	Hip	❑Left	❑Right
❑Neck	Arm	❑Left	❑Right	Thigh	❑Left	❑Right
❑Upper back	Elbow	❑Left	❑Right	Knee	❑Left	❑Right
❑Mid back	Wrist	❑Left	❑Right	Calf	❑Left	❑Right
❑Ribs	Hand	❑Left	❑Right	Ankle	❑Left	❑Right
❑Chest	Fingers	❑Left	❑Right	Foot	❑Left	❑Right
❑Abdomen	Buttock	❑Left	❑Right	Toes	❑Left	❑Right
❑Low Back	❑Pelvis					

In what areas did you experience lacerations (cuts)? ❑ ***N/A***

❑Head	Shoulder	❑Left	❑Right	Hip	❑Left	❑Right
❑Neck	Arm	❑Left	❑Right	Thigh	❑Left	❑Right
❑Upper back	Elbow	❑Left	❑Right	Knee	❑Left	❑Right
❑Mid back	Wrist	❑Left	❑Right	Calf	❑Left	❑Right
❑Ribs	Hand	❑Left	❑Right	Ankle	❑Left	❑Right
❑Chest	Fingers	❑Left	❑Right	Foot	❑Left	❑Right
❑Abdomen	Buttock	❑Left	❑Right	Toes	❑Left	❑Right
❑Low Back	❑Pelvis					

At the hospital, what areas were x-rayed? ❑ ***N/A***

❑Head	Shoulder	❑Left	❑Right	Hip	❑Left	❑Right
❑Neck	Arm	❑Left	❑Right	Thigh	❑Left	❑Right
❑Upper back	Elbow	❑Left	❑Right	Knee	❑Left	❑Right
❑Mid back	Wrist	❑Left	❑Right	Calf	❑Left	❑Right
❑Ribs	Hand	❑Left	❑Right	Ankle	❑Left	❑Right
❑Chest	Fingers	❑Left	❑Right	Foot	❑Left	❑Right
❑Abdomen	Buttock	❑Left	❑Right	Toes	❑Left	❑Right
❑Low Back	❑Pelvis					

Where did you experience pain on the day FOLLOWING the accident? ❑ ***N/A***

❑Head:	❑Left	❑Right ❑	Shoulder:	❑Left	❑Right	Hip	❑Left	❑Right
❑Neck:	❑Left	❑Right ❑	Arm:	❑Left	❑Right	Thigh	❑Left	❑Right
❑Upper back:	❑Left	❑Right ❑	Elbow:	❑Left	❑Right	Knee	❑Left	❑Right
❑Mid back:	❑Left	❑Right ❑	Wrist	❑Left	❑Right	Calf	❑Left	❑Right
❑Ribs:	❑Left	❑Right ❑	Hand	❑Left	❑Right	Ankle	❑Left	❑Right
❑Chest:	❑Left	❑Right ❑	Fingers	❑Left	❑Right	Foot	❑Left	❑Right
❑Abdomen:	❑Left	❑Right ❑	Buttock	❑Left	❑Right	Toes	❑Left	❑Right
❑ Low Back:	❑Left	❑Right ❑	Pelvis					

Patient's Signature:_____