AUTOMOBILE ACCIDENT QUESTIONNAIRE

Name: _____ **Date of Accident:** _____

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

Vehicle type:

❑ Car ❑ Truck ❑ Other

Your position in the vehicle:

❑Driver Passenger : ❑Front Passenger ❑Rear Passenger

Speed of your vehicle:

❑Stopped ❑Slowing ❑Parked ❑Moving at apprx ____MPH

Collision Type:

❑Driver Side Impact ❑Head On Collision ❑Passenger Side Impact ❑Rear Impact

Accident: Describe in your own Words What Happened: _____

_____

_____

CONDITIONS AT THE TIME OF THE ACCIDENT:

Time of day:
- ❑Full daylight
- ❑Dawn
- ❑Dusk
- ❑Night

Road Conditions:
- ❑Dry
- ❑Damp
- ❑Wet
- ❑Ice

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

Was the air bag deployed?
- ❑Car not equipped with air bag
- ❑Air bag deployed
- ❑Air bag not deployed

Position of YOUR head at time of impact?
- ❑Facing straight ahead
- ❑Tilted forward
- ❑Rotated to the left
- ❑Rotated to the right

Position of Your body at time of impact?
- ❑Straight
- ❑Tilted forward
- ❑Rotated to the left
- ❑Rotated to the right

Damage to vehicle YOU were in:
- ❑ minimal damage
- ❑ moderate damage
- ❑ severe damage
- ❑ totalled

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

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
- ❑Dazed
- ❑Disoriented
- ❑Weak
- ❑Nervous
- ❑Nauseated

Were you able to walk unaided?

❑Yes ❑No

Where did you go...?

- ❑Drove home
- ❑Was driven home
- ❑Taken to hospital via ambulance
- ❑Drove to hospital
- ❑Was driven to hospital

In what areas did you IMMEDIATELY feel pain?

❑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	Ankle	❑Left	❑Right
❑Ribs	Hand	❑Left	❑Right	Foot	❑Left	❑Right
❑Chest						
❑Abdomen						
❑Low Back						

In what areas did you experience lacerations (cuts)? _____

Were x-rays taken at the hospital,? _____

PLEASE CIRCLE ANY OF THE FOLLOWING YOU HAVE OR ARE NOW EXPERIENCING

Short Term Memory Loss	Inability to Concentrate	Crying spells or Weeping
Finding the right word when talking	Planning or Organization	Recurring Nightmares
Understanding what is said/read	Getting Lost	Helplessness
Making decisions or problem solving	Guilt	Depression
Slower speed of Thinking	Stuttering or Slurring speech	Outburst of Anger
Periods of "blacking out" or seizures	Blurry or Double Vision	Easily Frustrated
Problems coordinating hands or feet	Fatigue	Feeling of Fear or Anxiety
Change in the sense of smell or taste	Low Motivation	Decreased Sex Drive
Increased sensitivity to light or sound	Feelings of Sadness	Increased Sex Drive

ACTIVITIES OF DAILY LIVING ASSESSMENT

Automobile & Work Injuries

Please select the best answer from the 6 choices for each item

1. Pain Intensity

☐ I can tolerate the pain I have without using pain pills.
☐ The pain is bad but I try to manage without taking pills.
☐ Pain pills give considerable relief from pain.
☐ Pain pills give moderate relief from pain.
☐ Pain pills give very little relief from pain.
☐ Pain pills give no relief from pain.

2. Personal Care (washing, dressing, etc.)

☐ I can look after myself normally without causing extra pain
☐ I can look after myself normally but it causes extra pain.
☐ It is painful to look after myself and I am slow and careful.
☐ I need some help but manage most of my personal care.
☐ I need help every day in most aspects of self-care.
☐ I do not get dressed, wash with difficulty, & stay in bed.

3. Lifting

☐ I can lift heavy weights without extra pain.
☐ I can lift heavy weights but it causes extra pain.
☐ Pain prevents lifting heavy weights off the floor.
☐ Pain prevents lifting medium weights.
☐ I can lift only very light weights.
☐ I cannot lift or carry anything at all.

4. Walking

☐ Pain does not prevent me from walking any distance.
☐ Pain prevents me from walking more than one mile.
☐ Pain prevents me from walking more than ½ mile.
☐ Pain prevents me from walking more than 1/4 mile.
☐ I can only walk using a cane or crutches.
☐ I am in bed most of time & have help to the bathroom.

5. Sitting

☐ I can sit in any chair as long as I like.
☐ I can only sit in my favorite chair as long as I like.
☐ Pain prevents me from sitting for more than one hour.
☐ Pain prevents me from sitting more than 30 minutes.
☐ Pain prevents me from sitting more than 10 minutes.
☐ Pain prevents me from sitting at all.

6. Standing

☐ I can stand as long as I want without extra pain
☐ I can stand as long as I want but it causes extra pain.
☐ Pain prevents me from standing for more than one hour.
☐ Pain prevents me from standing for more than 30 min..
☐ Pain prevents me from standing for more than 10 minutes.
☐ Pain prevents me from standing at all.

7. Sleeping

☐ Pain does not prevent me from sleeping well.
☐ I can sleep well only by using pills.
☐ Even with pills I have less than 6 hours sleep.
☐ Even with pills I have less than 4 hours sleep.
☐ Even with pills I have less than 2 hours sleep.
☐ Pain prevents me from sleeping at all.

8. Sex Life

☐ My sex life is normal and causes no extra pain
☐ My sex life is normal but causes some extra pain.
☐ My sex life is nearly normal but is very painful.
☐ My sex life is severely restricted by pain.
☐ My sex life is nearly absent because of pain.
☐ Pain prevents any sex life at all.

9. Work Capacity / Social Life

☐ My activity is normal and gives me no extra pain.
☐ My activity is normal but increases the degree of pain.
☐ Pain limits me from more energetic interests or activities.
☐ Pain has restricted my work / social life considerably.
☐ Pain has restricted my social life to my home.
☐ I have no social or activity life because of pain.

10. Traveling

☐ I can travel anywhere without extra pain.
☐ I can travel anywhere but it gives me extra pain.
☐ Pain is bad but I manage journeys over 2 hours.
☐ Pain restricts me to journeys of less than one hour.
☐ Pain restricts me to short necessary trips under ½ hour.
☐ Pain restricts me from traveling except to the doctor