Eaton Chiropractic Center
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# Auto Accident Questionnaire

**Name** _____

1. What was the date of the accident?_____
2. What time did the accident occur?_____
3. How many vehicles were involved in the accident?_____
4. What was the estimated damage to the vehicle you were in? _____
5. What state did the accident occur in? _____
6. What city did the accident occur in? _____
7. What street or intersection were you on when the accident occured?
   _____
8. What direction were you traveling in? _____
9. What type of impact was the auto accident? _____

| | |
|---|---|
| □ Rear Ended | □ Hit another vehicle from behind |
| □ My vehicle was hit on passenger side | □ My vehicle was hit on driver side |

□ Other
_____

**10.** Did your vehicle hit anything after the accident?□ No □ Yes

if yes, please describe

_____

11. Where were you sitting in the vehicle during the accident?

_____

12. Did you know the accident was coming?

| |
|---|
| □ Unaware of impending collision |
| □ Aware & Relaxed |
| □ Aware & Braced |

13. What type of vehicle were you in? _____

| | | | |
|---|---|---|---|
| □ Subcompact | □ Compact | □ Mid Sized | □ Full Size |
| □ Pickup Truck | □ Mini Van | □ Van | □ Larger than 1 Ton |
| □ Mid size SUV | □ Large SUV | □ | □ |

14. What type of vehicle impacted yours?

| | | | |
|---|---|---|---|
| □ Subcompact | □ Compact | □ Mid Sized | □ Full Size |
| □ Pickup Truck | □ Mini Van | □ Van | □ Larger than 1 Ton |
| □ Mid size SUV | □ Large SUV | □ | □ |

15. At the time of the impact, how fast was your vehicle moving? _____

| | |
|---|---|
| □ Slowing Down | □ Stopped |
| □ Gaining Speed | □ Moving at a steady speed |

16. At the time of impact, how fast was the other vehicle moving? _____

| | |
|---|---|
| □ Slowing Down | □ Stopped |
| □ Gaining Speed | □ Moving at a steady speed |

17. During and after the crash what happened to your vehicle? (Check all that apply)

| | |
|---|---|
| □ kept going straight | □ spun around |
| □ kept going straight hitting a car in front | □ spun around and hit a stationary object |
| □ was hit by another vehicle | □ hit a stationary object |

18. Did you lose consciousness during the accident? -yes - no

19. How was your head positioned during the accident? _____

20. How was your torso positioned during the accident? _____

21. How were your hands positioned during the accident? _____

22. Did your head hit anything during the accident? □ no □ yes

Please describe_____

23. Did your face hit anything during the accident? □ no □ yes

Please describe_____

24. Did your shoulders hit anything during the accident? □ no □ yes

Please describe_____

25. Did your neck hit anything during the accident? - □ no □ yes

Please describe_____

26. Did your chest hit anything during the accident? □ no □ yes

Please describe_____

27. Did your hips hit anything during the accident? □ no □ yes

Please describe_____

28. Did your knees hit anything during the accident? □ no □ yes

Please describe_____

29. Did your feet hit anything during the accident? □ no □ yes

Please describe_____

30. What kind of headrest was in your vehicle?
- movable fixed headrest
- nonmovable fixed headrest
- no headrest

31. Where was the headrest positioned on your head? _____

32. Did you have your seatbelt on during the accident? □ no □ yes

33. Did you slide out of your seatbelt during the accident? □ no □ yes

34. What was damaged in your vehicle? (Circle all that apply)

| | | |
|---|---|---|
| □ windshield | □ rear bumper | □ knee bolster |
| □ steering wheel | □ front bumper | □ back right door |
| □ seat frame | □ trunk | □ completely totaled |
| □ side window | □ front left door | □ |
| □ dashboard | □ front right door | □ |
| □ rear window | □ back left door | □ |

35. Choose the items that dented inward

| | | |
|---|---|---|
| □ floorboards | □ side door | □ dashboard |

36. Choose the doors that would not open as a result of the accident

| | |
|---|---|
| □ front left | □ front right |
| □ rear left | □ rear right |

37. Did you go to the hospital? □ no □ yes If no, why and do not answer 38-43

_____

38. How did get to the hospital? _____

39. What was the name of the hospital? _____

40. Were you hospitalized over night? _____

41. Circle what you were prescribed at the hospital
- pain medication - muscle relaxors - neck brace

42. Did you recieve any stitches for any cuts at the hospital? _____

43. Were x rays taken at the hosiptal? If yes, which area was taken?

_____

44. Was an MRI done? □ no □ yes
Area Done_____