AUTOMOBILE ACCIDENT QUESTIONNAIRE

Patient Name: _____ Date: _____

A. What type of vehicle were you in?: ___Car ___Pickup ___Van ___Other
Vehicle type?: ___Subcompact ___Compact ___ Full Size ___Mid-Size ___Other

B. Where were you sitting in the vehicle?: ___Driver ___Front Passenger ___Rear Passenger ___Other

C. Was your vehicle?: ___Stopped ___Slowing down ___Moving ___MPH

D. What damage was done to your vehicle?: ___ Minimal ___Moderate ___Extensive ___Totaled ___Unsure

E. What was other vehicle?: ___Car ___Pickup ___Van ___Other
Vehicle type?: ___Subcompact ___Compact ___Full Size ___Mid-Size ___Other

F. How did this vehicle strike the vehicle you were in?: ___Head on ___From Left ___From Right ___Rear Ended ___Sideswiped on Right ___Sideswiped on Left ___Other

G. What damage was done to this vehicle?: ___Minimal ___Moderate ___Extensive ___Totaled ___Unsure

H. Did second vehicle strike vehicle you were in?: ___Yes ___No

I. Were traffic citations issued?: ___Yes ___No ___Unsure
If yes, to: ___Driver of vehicle you were in ___Driver of other vehicle ___You

J. Were you prepared for the accident? ___Yes ___No
___Accident a complete surprise ___Aware of impending collision ___Braced for impact

K. Were you wearing a restraint belt?: ___Yes ___No