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An Integrated Approach to Wellness

AUTO INJURY QUESTIONNAIRE

PATIENT NAME: ____ **DATE:** ___________

Where did the auto accident occur? _______________________________ Date of accident: ____________

Please describe in your own words what happened during the accident.

____
____
____

DESCRIBE VEHICLE YOU WERE IN DURING THE ACCIDENT

Vehicle type: ☐Car ☐Pickup ☐Van ☐Truck ☐SUV ☐Bus ☐Other______________

Vehicle size: ☐Subcompact ☐Full-size ☐Compact ☐Mini ☐Mid-size ☐Light ☐Heavy ☐Other__________

What was your position in the vehicle? ☐Driver ☐Passenger ☐ Other: ________________

If passenger, where were you seated? ☐Front Passenger ☐Rear Passenger: ☐Middle ☐Left ☐Right ☐Third Seat (rear)

Speed of your vehicle: ☐Stopped ☐Moving moderately ☐Parked ☐Moving Fast
☐Slowing ☐Moving at approx. ____MPH ☐Moving slowly

Why was the vehicle slowed/stopped? ☐Traffic Signal ☐Parking ☐Pedestrian ☐Traffic ☐Stop Sign ☐Busy Intersection

Collision Type: ☐Driver Side Impact ☐Head On Collision ☐Front Impact ☐Pedestrian Incident
☐Passenger Side Impact ☐Rear Impact

DESCRIBE THE OTHER VEHICLE INVOLVED IN THE ACCIDENT

Vehicle type: ☐Car ☐Pickup ☐Van ☐Truck ☐SUV ☐Bus ☐Other______________

Vehicle size: ☐Subcompact ☐Full-size ☐Compact ☐Mini ☐Mid-size ☐Light ☐Heavy ☐Other__________

CONDITIONS AT TIME OF ACCIDENT

Time of day: Full daylight Dusk Night

Road Conditions: Dry Damp Wet Snow-covered Ice-covered Patchy Ice/snow

Visibility: Excellent Good Fair Poor

Visibility compromised by: Brightness Darkness Rain Snow Fog Traffic

DESCRIBE THE MOMENT OF IMPACT

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 your foot on the brake pedal? ☐Yes ☐No ☐Knocked off by impact

Was the air bag deployed? ☐Car not equipped with air bag ☐Air bag deployed ☐Air bag not deployed

What position was YOUR headrest in? ☐High position ☐Middle position ☐ Low position

Position of your HEAD: □Facing straight-ahead □Tilted forward □Rotated to the left □Rotated to the right

Was your head thrown? □Backward and then forward □Forward then backward □To the left □To the left then right □To the right □To the right then left

Position of your BODY: □Straight □Tilted forward □Rotated to the left □Rotated to the right

Was your body thrown? □Backward and then forward □Forward then backward □To the left □To the left then right □To the right □To the right then left □Across the vehicle □Outside the vehicle □Under the vehicle

Damage to vehicle YOU were in incurred: □Minimal damage □Moderate damage □Severe damage □Was totaled □Not known

Citations: □None issued □Yourself □Driver of vehicle patient was a passenger of □Driver of other vehicle □Not sure

WHAT PART OF THE VEHICLE DID YOUR BODY STRIKE AGAINST?

HEAD

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

TORSO

□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

□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

□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

□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

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

AT THE TIME OF ACCIDENT

Did you lose consciousness? Yes No

Were you able to walk unaided? Yes No

Immediately after the accident, did you feel? Dizzy Dazed Weak Nervous Disoriented Nauseated

Did you feel any numbness or tingling? Yes No If yes, describe where: ______________________________________

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

Hospital Name: ____Date of hospital visit: ____/____/______

Were you admitted to the Hospital? Yes No

If you went to the hospital, what areas were x-rayed?

☐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 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	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 (if any) did you experience lacerations (cuts)?

☐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						

AFTER THE ACCIDENT

On the next day, did your discomfort (circle one): increase remain the same decrease

Where did you experience pain on the day FOLLOWING the accident?

☐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						

Did your major complaint exist before the accident? Yes No

As result of the accident, did you have to take time off from work or school? Yes No

If yes, please list dates missed: ____

Do you have an attorney? Yes No

Attorney Name: ____**Phone Number**: ___________________________
Attorney Address: ____

Insurance Company Name: ______________________________**Phone Number**: ______________ **Claim #**: ______________

Claims Address: ____**Contact Person:** ______________________

PATIENT/PARENT GUARDIAN SIGNATURE: ____ **DATE:** ______________