CAR CRASH QUESTIONNAIRE

Patient Name:_____ Date:_____

Street (location) where crash occurred:_____

City:_____ State:_____ Date of Crash:_____ ☐ AM ☐ PM

Police come to the scene? ☐ Yes ☐ No Was a police report made? ☐ Yes ☐ No Number of passengers in your vehicle_____

What is the estimated cost to repair your vehicle? $_____

DESCRIBE THE CRASH:_____

_____

COLLISION DESCRIPTION: ***Check all that apply to you.*** Were you involved in the following type of accident?

☐ Single-car crash ☐ Two-vehicle crash ☐ Three or more vehicles ☐ Ran off road ☐ Hit guardrail/tree/wall
☐ Rear-end crash ☐ Side crash ☐ Head-on crash ☐ Rollover

INDICATE YOUR SEATING POSITION: ☐ Driver ☐ Front passenger ☐ Left rear passenger ☐ Right rear passenger

DESCRIBE THE VEHICLE YOU WERE IN: Make_____ Model year_____

☐ Small car ☐ Mid-sized car ☐ Van ☐ Full-sized car ☐ Pick-up truck/sport utility ☐ Large truck, bus, or semi-truck

If ***not*** in your own auto: Name of owner: Relationship:

Owners Insurance Company:_____

DESCRIBE THE OTHER VEHICLE: Make_____ Model year_____

☐ Small car ☐ Mid-sized car ☐ Van ☐ Full-sized car ☐ Pick-up truck/sport utility ☐ Large truck, bus, or semi-truck

ESTIMATED CRASH SPEEDS:

Estimate how fast your vehicle as moving at the time of crash. _____mph ☐ Unknown
Estimate how fast the other vehicle was moving at the time of crash _____mph ☐ Unknown

AT THE TIME OF IMPACT YOUR VEHICLE WAS: ☐ Slowing down ☐ Stopped ☐ Gaining speed ☐ Moving at a steady speed

AT THE TIME OF IMPACT THE OTHER VEHICLE WAS: ☐ Slowing down ☐ Stopped ☐ Gaining speed ☐ Moving at a steady speed

DURING AND AFTER THE CRASH, YOUR VEHICLE:

☐ Kept going straight, not hitting anything ☐ Kept going straight, hitting car in front ☐ Was hit by another car
☐ Spun around, not hitting anything ☐ Spun around, hitting another car ☐ Spun around, hitting another object

SEATBELT USAGE AND STEERING WHEEL HAND PLACEMENT:

Were you wearing a seatbelt? ☐ Yes ☐ No Lap and shoulder strap? ☐ Yes ☐ No Lap belt only? ☐ Yes ☐ No
Were you holding onto the steering wheel? ☐ Yes ☐ No

REAR END COLLISION ONLY: My seat had moveable/adjustable head restraints: ☐ Yes ☐ No
My seat had fixed head restraints: ☐Yes ☐ No My seat had head restraints: ☐ Yes ☐ No

AWARENESS AND BODY POSITION DESCRIPTIONS: ***Check all areas that apply to you.***

☐ You were unaware of the impending collision. You *did* not see or hear brakes prior to impact.

☐ You were aware of the impending crash and relaxed before the collision.

☐ You were aware of the impending crash and braced yourself.

☐ Your head and torso were facing straight ahead.

☐ You had your head and/or torso turned at the time of collision. ☐ Turned left ☐ Turned right

☐ You were leaning forward at the time of impact resulting in a gap between your body and seat-back.

☐ You were seated/positioned normally.

Please complete the reverse side

Were you knocked unconscious? ☐ Yes ☐ No List any broken bones: _____

Taken to the emergency room? ☐ Yes ☐ No Name of ER _____City_____

Were you hospitalized? ☐ Yes ☐ No Name of hospital _____City_____

How soon did you first notice any pain-soreness after your injury? ☐ Immediately ☐___Hours later ☐ ___Days later

Did you have any cuts or lacerations? ☐ Yes ☐ No List:_____

Did you have bruises? ☐ Yes ☐ No List:_____

Indicate if your body hit something or was hit by ay of the following: *Check all areas that apply to you*

☐ Right Side of Head Hit:_____ ☐ Lift Side of Head Hit: _____

☐ Right Side of Face Hit: _____ ☐ Left Side of Face Hit:_____

☐ Right Shoulder Hit:_____ ☐ Left Shoulder Hit:_____

☐ Right Arm/Hand Hit: _____ ☐ Left Arm/Hand Hit: _____

☐ Right Side of Chest Hit: _____ ☐ Left Side of Chest Hit: _____

☐ Front Chest Wall Hit:_____ ☐ Abdomen Hit: _____

☐ Right Hip Hit: _____ ☐ Left Hip Hit: _____

☐ Right Knee Hit: _____ ☐ Left Knee Hit:_____

☐ Right Leg Hit:_____ ☐ Left Leg Hit: _____

☐ Right Foot Hit: _____ ☐ Left Foot Hit: _____

Insurance Information

At Fault Insurance Company:_____PH#_____

Name of insured: _____Claim# _____

I have made a report to the insurance company regarding this accident? ☐ Yes ☐ No

Your Insurance Company: _____PH#_____

Name of insured: _____Relationship: _____

I do not own and auto:☐ Yes ☐ No I own an auto but it was not insured at the time of injury: ☐ Yes ☐ No

In order to provide necessary documentation of your injuries, please advise if you are represented by an attorney for this accident:

Name of attorney:_____PH#_____

Address: _____ City:_____

If you are not currently represented by an attorney, are you planning on obtaining an attorney: ☐ Yes ☐ No

_____ _____

Signature Date