AUTOMOTIVE CRASH QUESTIONNAIRE

Patient's Name: _____ Date: _____

State Driver's License #: _____

Name of Insurance Company: _____

Name of Insured: _____ Claim #: _____

Date of Injury: _____ Time of Injury: _____

What city did the crash occur in? _____

What is the estimated damage to your vehicle? _____

Who made the damage estimates on your car? _____

Who owns the vehicle you were involved in? _____

Who was responsible for the accident? _____

❑ Yes ❑ No Did you report the injury to the insurance company?

❑ Yes ❑ No Have you filed for Personal Injury Protection "PIP" benefits with your auto insurance company?

❑ Yes ❑ No Do you have an attorney for this case? If yes,
Name of Attorney: _____
Address: _____
_____
Phone: _____

❑ Yes ❑ No Was the accident on the job?

❑ Yes ❑ No Did the police come to the accident scene and make a report?

❑ Yes ❑ No Were you cited by the police?

Describe how the crash happened: _____
_____
_____
_____
_____

Draw a diagram of the accident scene. Be sure to label street names, intersections, etc.

COLLISION DESCRIPTION

What type of accident were you involved in? (Check all that apply.)

❑ single car crash ❑ two-vehicle crash ❑ three or more vehicles
❑ rear end collision ❑ sideswipe crash ❑ rollover
❑ head on collision ❑ hit guardrail/tree ❑ ran off road

You were the: ❑ driver ❑ front passenger ❑ rear passenger

Describe the vehicle you were in:

Make and model: _____ Year: _____

❑ compact car ❑ mid-sized car ❑ full-sized car
❑ pick-up truck/sports utility ❑ large truck/large SUV ❑ large bus or semi-truck

If any, describe the other vehicle(s):

❑ compact car ❑ mid-sized car ❑ full-sized car
❑ pick-up truck/sports utility ❑ large truck/large SUV ❑ large bus or semi-truck

Estimated crash speeds:

Estimate how fast your vehicle was moving at the time of the crash: _____mph
Estimate how fast the other vehicle was moving at the time of the crash: _____mph

At the time of impact, YOUR vehicle was:

❑ slowing down ❑ gaining speed ❑ stopped ❑ moving at a steady speed

At the time of impact, the OTHER vehicle was:

❑ slowing down ❑ gaining speed ❑ stopped ❑ moving at a steady speed

During and after the crash, YOUR vehicle:

❑ kept going straight, not hitting anything ❑ spun around, not hitting anything
❑ kept going straight, hitting car in front ❑ spun around, hitting another car
❑ was hit by another vehicle ❑ spun around, hitting object (not a car)

Describe yourself during the crash:

❑ Yes ❑ No You were aware of the impending collision. Did you see or hear brakes prior to the impact?
❑ Yes ❑ No Were relaxed before impact?
❑ Yes ❑ No Did you brace yourself before impact?
❑ Yes ❑ No Was your body, torso, and head facing straight ahead?
❑ Yes ❑ No Was your head &/or torso turned to the *left* at the time of collision?
❑ Yes ❑ No Was your head &/or torso turned to the *right* at the time of collision?
❑ Yes ❑ No Were you intoxicated (alcohol) at the time of the crash?
❑ Yes ❑ No Were you wearing a seatbelt?
❑ Yes ❑ No Does your seatbelt have a shoulder harness?
❑ Yes ❑ No Were you holding onto the steering wheel at the time of impact?
❑ Yes ❑ No If you were involved in a rear-end crash, did your car separate away from the striking vehicle after the crash? If so, you are indicating that after the crash, your car was pushed away from the striking vehicle.

Indicate if your body hit something or if your body was hit by any of the following. Please draw lines, matching the left side to the right side.

head	windshield
face	side window
shoulder	side door
arm/hand	dashboard
front chest wall	knee bolster/glove compartment
side chest wall	seatbelt
hip/abdomen	frame of car near windows
knee	roof of vehicle
leg	another occupant/animal
foot	other _____

Were any vehicle parts damaged in your car? If so, which ones?

❑ windshield ❑ seat frame ❑ knee bolster
❑ steering wheel ❑ side-rear window ❑ other: _____
❑ dash ❑ mirror ❑ other: _____

What were the road conditions at the time of the accident?

❑ dry ❑ wet ❑ icy ❑ other: _____

Answer this section regardless of the type of crash; indicating those relevant to your case:

❑ Yes ❑ No Did any of the front or side structures, such as the dashboard, side door, or floorboard of your car dent inward during the crash?

❑ Yes ❑ No Did the side door touch your body during the crash?

❑ Yes ❑ No Was the door(s) of your vehicle damaged to the point where you couldn't open it?

❑ Yes ❑ No Have you noticed any visible bruising on your body ever since the accident? If yes, where? _____

Have you been unable to work since the injury?

❑ Yes ❑ No If yes, how much did you miss work? ❑ partially ❑ completely

List the dates you were absent from work: From_____ To_____

Did you experience neck pain and/or back pain so severe that you were unable to get out of bed? If yes, how many hours after the accident did you develop this disabling level of pain?

❑ Yes; _____hours ❑ No

Answer this section if you were involved in a REAR-END COLLISION ONLY:

Does your vehicle have:

- ❑ movable / adjustable head restraints
- ❑ fixed, non-movable head restraints
- ❑ no headrests in my vehicle

Please indicate how your <u>head restraint</u> was positioned at the time of the crash:

- ❑ level with the top of your head
- ❑ midway height on the back of your head
- ❑ lower height on the back of your head
- ❑ located at the level of your neck
- ❑ located at the level of your shoulder blades (upper back) below neck

Estimate the distance between the back of your head & the front of the headrest.

Approximately _____ inches.

❑ Yes ❑ No Did your car separate away from the striking vehicle after the crash? If yes, you are indicating that after the crash, your car was pushed away from the striking vehicle and your car did not stay attached.

What happened right after the accident?

❑ Yes ❑ No Did you go to the emergency room afterward?
If yes, Date:_____ Time:_____
Name of emergency room:_____ City:_____

❑ Yes ❑ No Did you go to the emergency room in an ambulance?

❑ Yes ❑ No Did you or another person drive you to emergency?
Name of other person: _____

❑ Yes ❑ No Were you hospitalized after being seen in the emergency room?
If yes, how many days were you hospitalized? _____

❑ Yes ❑ No Did the emergency room doctor take X-rays?
If yes, what regions were x-rays taken? (Check all that apply.)

❑ skull/face	❑ ribs/chest	❑ neck or middle back
❑ collar bone	❑ lower back	❑ shoulder, arm, or hand
❑ leg or foot	❑ pelvis/hip	❑ other:_____

❑ Yes ❑ No Did the hospital or clinic take a MRI or CT of your body?
If yes, indicate the area of body tested.
❑ skull ❑ neck ❑ lower back, pelvis/hip ❑ other

❑ Yes ❑ No Did you have broken bones/fractures? If yes, where? _____

❑ Yes ❑ No Did you have a cast put on the fracture? If yes, where? _____

❑ Yes ❑ No Did you have any dislocations? If yes, where? _____

❑ Yes ❑ No Did you have any cuts or lacerations? If yes, where? _____

❑ Yes ❑ No Did you have any skin abrasions? If yes, where? _____

❑ Yes ❑ No Did you need stitches for any cuts? If yes, where? _____

What happened right after the accident? (continued)

❑ Yes ❑ No Did you have any visible bruises or lumps? Where? _____

❑ Yes ❑ No Did the emergency room doctor give you any medications?
If yes, check all that apply and also write the name of medication:
❑ pain pills: _____
❑ muscle relaxants: _____
❑ other medications: _____

❑ Yes ❑ No Were you told you have a herniated disc? If yes, where? _____

❑ Yes ❑ No Were you given a neck brace to wear?

❑ Yes ❑ No Did you require any surgery after the accident?
If yes, what type? _____ Date:_____

❑ Yes ❑ No Were you hospitalized overnight? If yes, when? _____

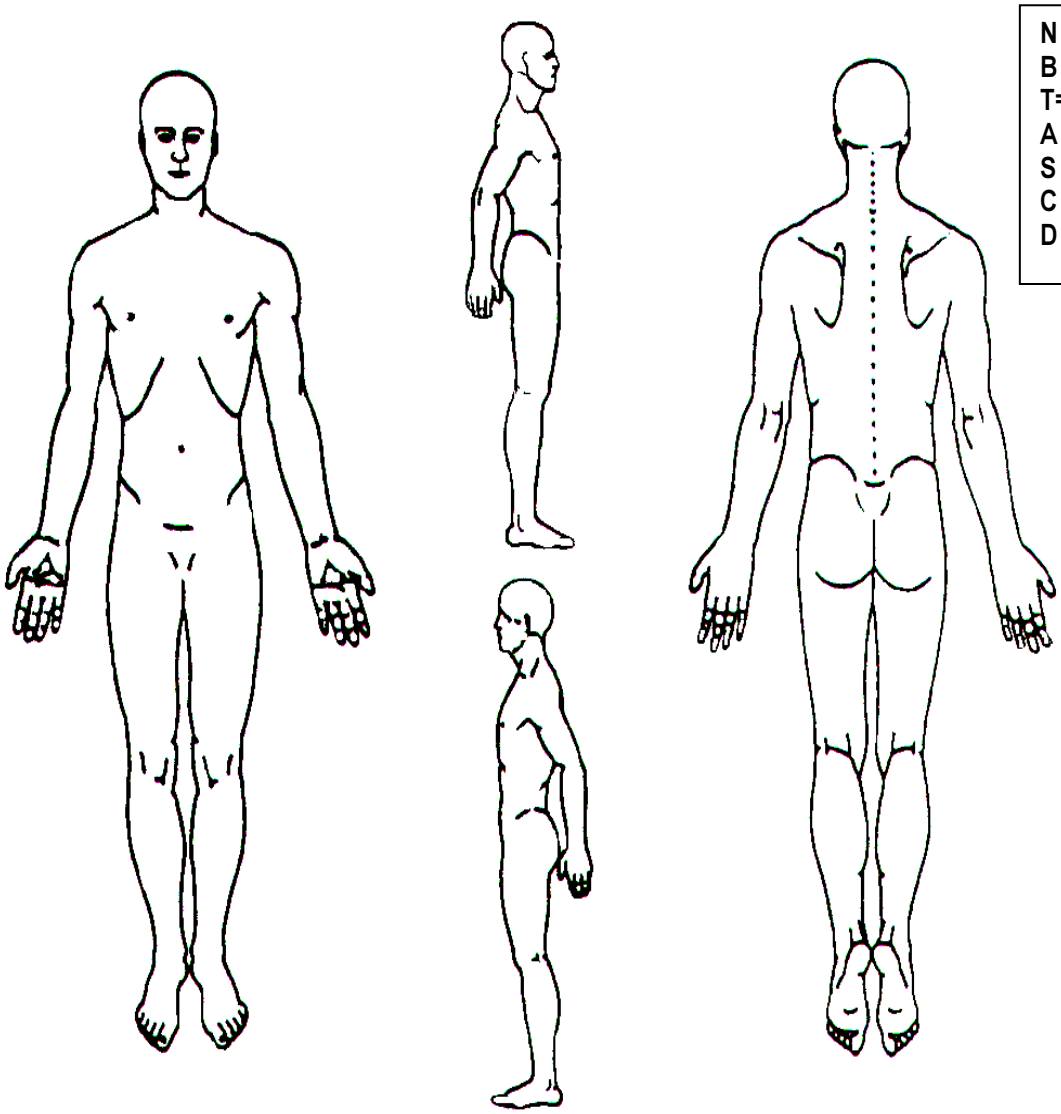
How soon after your injury did you first notice any pain or soreness?

❑ immediately / less than 30 minutes ❑ within ___ hours after the injury
❑ within ____ days after the injury

If you did not see a doctor for the first time within the two weeks, indicate why. (Check all that apply only if you had delay in seeing a doctor):

❑ no pain was noticed ❑ thought pain would go away
❑ no appropriate schedule available ❑ no transportation
❑ work/home schedule conflicts ❑ other: _____

Please mark the areas on your body where you feel the described sensations. Use the appropriate symbol. Mark areas of radiation. Include all affected areas.



N = Numb
B = Burn
T= Tingles / Pins / needles
A = Aches
S = Sharp / Stabbing
C = Cramping
D = Dull

Since the accident, On a scale between 0-10, please rate your pain levels below:

What is your **average** pain level? _____

What is your pain level at its **best**? _____

What is your pain level at its **worst**? _____

List and describe the doctors/therapists you have seen and all the tests done since the injury. Start with the emergency room (if you went), then the first doctor you saw after your injury. List in order all of the doctors, therapists, and massage therapists up to your last doctor/therapist seen. Check all that apply for each of the following:

Name of hospital/doctor/therapist/center: _____
Specialty: _____ Date first seen: _____
Treatment type: _____ Treatment frequency: _____
Treatment duration: _____ Currently under treatment: ❑ Yes ❑ No
Any disability? ❑ Yes; describe: _____
❑ No
Special test(s): _____ Referred to: _____
Did treatment help? ❑ Yes ❑ No ❑ made condition worse
Notes: _____

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❑ No
Special test(s): _____ Referred to: _____
Did treatment help? ❑ Yes ❑ No ❑ made condition worse
Notes: _____
_____

Other Comments: _____

I certify that the above statements are true to the best of my knowledge.

_____ _____
Patient Signature **Date**