Therapeutic Massage & Bodywork LLC

Auto Accident Questionnaire

Name: _____

Date of Accident:_____

Describe the accident in your own words (please include location):

_____

_____

_____

_____

_____

_____

_____

1. What was your position in the car?

- ☐ Driver Were your hands on the steering wheel?
  - ☐ Left
  - ☐ Right
  - ☐ Both
- ☐ Passenger Were you sitting in the:
  - ☐ Driver
  - ☐ Front Passenger
  - ☐ Passenger Rear
  - ☐ Driver Rear

2. Did your vehicle strike another vehicle or object?

- ☐ Yes
- ☐ No

Type?_____

3. Was your vehicle struck by another vehicle?

- ☐ Yes
- ☐ No

Type?_____

4. Estimate the speed at time of accident:

Your Vehicle: _____mph

Other vehicle: _____mph

5. Angles of impact:

First Collision:

- ☐ Front
- ☐ Back
- ☐ Left
- ☐ Right

If Second Collision:

- ☐ Front
- ☐ Back
- ☐ Left
- ☐ Right

6. What is the estimated damage to your vehicle?

$_____

7. Were you wearing a seat belt?

- ☐ Yes
- ☐ No

8. Did you brace for impact?

- ☐ Yes with:
  - ☐ Hands
  - ☐ Feet
  - ☐ Both
- ☐ No

9. Which way were you facing at the time of impact?

- ☐ Straight ahead
- ☐ Right
- ☐ Left

10.Did you strike anything in your vehicle at the time of impact?

- ☐ Yes
- ☐ No

If yes, specify what part of your body struck any of the following: i.e. head, chest, shoulder, knee, etc.

- ☐ Steering Wheel_____
- ☐ Dashboard _____
- ☐ Windshield_____
- ☐ Roof_____
- ☐ Left side door_____
- ☐ Right side door_____
- ☐ Left window_____
- ☐ Right window_____
- ☐ Other_____

11. Did the seat back bend/ break?

- ☐ Yes
- ☐ No

12. Immediately following the accident, how did you feel?

- ☐ Dizzy/ dazed
- ☐ Disoriented
- ☐ Nervous
- ☐ Nauseous
- ☐ Upset
- ☐ Weak
- ☐ Other_____

13. Did you lose consciousness?

- ☐ Yes: for how long?_____
- ☐ No

14. Did you go to the hospital?

- ☐ No
- ☐ Yes: Were you admitted?
  - ☐ No
  - ☐ Yes: How long?_____

15. What treatment was given at hospital?

- ☐ None
- ☐ Placed in a cervical collar
- ☐ X-rays/ Imaging
- ☐ Stitches
- ☐ Bandaged
- ☐ Given pain medication
- ☐ Given instructions regarding concussions
- ☐ Given instructions regarding sprains/ strains
- ☐ Physical therapy
- ☐ Referred to this office
- ☐ Referred to other office_____
- ☐ Instructed to call Primary Care Physician
- ☐ Instructed to call an Orthopedic Surgeon
- ☐ Other_____

16. Have you seen any other doctor/ provider of care as a result of this accident?

- ☐ Yes
- ☐ No

Doctor/ Provider's name:

_____

Date Completed:____/_____/_____