

Houma-Thibodaux Spine & Rehab.

Automobile Accident Questionnaire

Patient Name _____ Date of Accident _____

Age _____ Were you a **driver** **passenger** **pedestrian**

Were you struck from **behind** **rt side** **lt side** **front** **auto was parked**

Did your car strike the other vehicle? **Yes** **No** Did another vehicle strike yours? **Yes** **No**

As a result of the accident, were traffic citations issued to you? **Yes** **No** To the driver of the other vehicle? **Yes** **No**

To the driver of the vehicle you were in, if you were a passenger? **Yes** **No**

Please list the extent of all injuries as you know them _____

What is your current occupation? _____

Did you miss any time from work due to this accident/ **Yes** **No** If yes, from _____ to _____

Details of the accident:

1. Were you wearing your seat belt? **Yes** **No**

2. What was the make and model of your vehicle? _____

3. Were you driving? **Yes** **No** If yes, how fast? _____

4. If you were stopped, were you? **in traffic** **at a stop light** **at a stop sign**

5. What type of vehicle struck yours? _____ Speed of other vehicle? _____

6. Was your vehicle equipped with an airbag? **Yes** **No** If yes, did it deploy? **Yes** **No**

7. Were you aware that an accident was going to occur? **Yes** **No**

8. Was the position of your headrest **low** **mid height** **fully extended**

9. Was the position of your head at the time of impact **rotated to the rt.** **rotated to the lt.** **facing forward**

10. Were the road conditions **Wet** **Dry**

11. Did you hit your head? **Yes** **No** If yes, on what? _____ Did you lose consciousness? **Yes** **No**

12. Did any part of your body strike anything inside of the vehicle you were in upon impact? **Yes** **No** If yes, explain _____

13. Did you have immediate pain after the accident? **Yes** **No** If yes, what type of pain did you have? _____

14. Did your pain begin **about 15 mins after accident** **several hrs after accident** **that night** **following day** **other**

How did you feel after the accident **pain** **dazed** **disoriented**

15. Was your vehicle towed from the scene? **Yes** **No** What was the damage to the vehicle you were in? _____

16. Were you taken to the ER? **Yes** **No** If yes, **via ambulance** **via family member/friend** **via yourself**

17. Did you report to the emergency room or family physician with your own transportation? **Yes** **No** If yes, where were you taken? _____

18. Were X-rays taken? **Yes** **No**

19. Were you prescribed medication? **Yes** **No** If yes, what medications were prescribed? _____

20. What is your current chief complaint?(What hurts the most) _____

Your Ins. Co. _____ Ph # _____

Medpay coverage? **Yes** **No** Claim # _____ Adjuster _____

At fault driver _____ Ins. Co. _____

Ph # _____ Claim # _____

Attorney _____ Ph. # _____

Address _____

Patient/Guardian Signature

Date

Dr. Notes _____

