



— GET WELL —  
CHIROPRACTIC

Case Number \_\_\_\_\_

Today's Date \_\_\_\_\_

CA \_\_\_\_\_

DC \_\_\_\_\_

### Automobile Accident Questionnaire

Title: \_\_\_\_\_ First: \_\_\_\_\_ MI: \_\_\_\_\_ Last: \_\_\_\_\_

Date of accident: \_\_\_\_\_ Time of accident: \_\_\_\_\_:\_\_\_\_\_ am / pm

State in which accident occurred? \_\_\_\_\_ Speed of the vehicle you were in: \_\_\_\_\_ mph

Where were you in the vehicle? \_\_\_\_\_

Vehicle type: ☐ Sub-compact ☐ Mid-size ☐ Full-size ☐ Pickup truck ☐ Sport-utility vehicle

☐ Mini-van ☐ Other: \_\_\_\_\_

Was the vehicle accelerating? ☐ No ☐ Yes

What was your vehicle doing immediately prior to impact?

- ☐ Changing lanes ☐ Slowing for traffic congestion ☐ Stopped for a stop sign  
☐ Stopped for a traffic light ☐ Turning left at an intersection ☐ Turning right at an intersection

What was your vehicle's point of impact?

- ☐ Front bumper ☐ Left front fender ☐ Left rear fender ☐ Left side  
☐ Rear bumper ☐ Right front fender ☐ Right rear fender ☐ Right side

Amount of damage to your vehicle:

- ☐ Minimal ☐ Moderate ☐ Extensive ☐ Totaled ☐ Unsure ☐ Other: \_\_\_\_\_

Road condition/s:

- ☐ Dry ☐ Damp ☐ Wet ☐ Mostly dry with the first minutes of rain  
☐ Sandy ☐ Muddy ☐ Black ice ☐ Covered with leaves or other debris  
☐ Raining ☐ Snowing ☐ Icy ☐ Covered with gravel

Visibility:

- ☐ Excellent with bright sunlight ☐ Excellent with overcast light ☐ Reduced at dawn  
☐ Reduced at dusk ☐ Reduced at night ☐ Reduced due to fog  
☐ Reduced due to rain ☐ Reduced due to snow

Was another vehicle involved? ☐ No ☐ Yes—how many: \_\_\_\_\_

Which vehicle hit the other: \_\_\_\_\_

Was a police report filed? ☐ No ☐ Yes—Can you provide our office with a copy? ☐ No ☐ Yes

### At Impact

Airbags deployed: ☐ No ☐ Yes

Position of headrest:

- ☐ Adjusted high ☐ Adjusted low ☐ All the way up  
☐ All the way down ☐ Properly adjusted ☐ Improperly adjusted

Type/s of seat restraint/s you were wearing:

☐ A shoulder harness only    ☐ A lap belt only    ☐ No seatbelts    ☐ Seatbelts with shoulder harness

Were you prepared for impact?    ☐ No    ☐ Yes

Was the driver's foot on the brake at the time of impact?    ☐ No    ☐ Yes—Was it knocked off?    ☐ No    ☐ Yes

What was the position of your head and neck prior to impact?

☐ Down    ☐ Down and to the left    ☐ Down and to the right  
☐ Level and to the left    ☐ Level and to the right    ☐ Straight ahead  
☐ Up    ☐ Up and to the left    ☐ Up and to the right

Did you lose consciousness?    ☐ No    ☐ Yes

Did you receive emergency care at the scene?    ☐ No    ☐ Yes

Where did you go immediately after the accident?

☐ Home    ☐ To a walk-in emergency clinic    ☐ To continue with scheduled plans  
☐ To work    ☐ To the hospital emergency room    ☐ Other—\_\_\_\_\_

## Other Vehicle

Other vehicle type:    ☐ Sub-compact    ☐ Mid-size    ☐ Full-size    ☐ Pickup truck    ☐ Sport-utility vehicle  
                                  ☐ Mini-van    ☐ Other:\_\_\_\_\_

Speed of the other vehicle:\_\_\_\_\_mph

Was the vehicle accelerating?    ☐ No    ☐ Yes

What was the other vehicle's point of impact?

☐ Front bumper    ☐ Left front fender    ☐ Left rear fender    ☐ Left side  
☐ Rear bumper    ☐ Right front fender    ☐ Right rear fender    ☐ Right side

Amount of damage to the other vehicle (if known): \$\_\_\_\_\_

What was the other vehicle doing immediately prior to impact?

☐ Changing lanes    ☐ Slowing for traffic congestion    ☐ Stopped for a stop sign  
☐ Stopped for a traffic light    ☐ Turning left at an intersection    ☐ Turning right at an intersection

Additional information:\_\_\_\_\_

\_\_\_\_\_

*I certify that the information provided above is accurate and complete to the best of my knowledge.*

\_\_\_\_\_  
Patient Name (Please Print)

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Witness

### For office use only:

Patient referred for MRI:    ☐ No    ☐ Yes—Name:\_\_\_\_\_

Patient referred to a neurologist:    ☐ No    ☐ Yes—Name:\_\_\_\_\_

Referring chiropractor:\_\_\_\_\_