Automobile Crash Questionnaire

Date of your accident:____________________Number of vehicles in collision ______________________________

Number of people in your vehicle___________ Where did the accident occur______________________________

Your Auto Insurance Company:_________________________Claim Number:________________________________

At Fault Auto Insurance Company:______________________Claim Number:________________________________

About Your Motor Vehicle Accident

How fast were the involved vehicles traveling at the time of impact?

Your Vehicle: ☐ 0-10mph ☐ 10-25mph ☐ 25-50mph ☐ more than 50mph

Other Vehicle: ☐ 0-10mph ☐ 10-25mph ☐ 25-50mph ☐ more than 50mph

Your Vehicle: ❑ Hit another vehicle ❑ Was hit in the: ❑ Right side ❑left side ❑Rear ❑Front

Who was at fault: ❑ I was at fault ❑ Other driver was at fault ❑ under investigation/unknown at this time

In your own words please describe what happened.

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About Your Body at the Time of Impact

Were you the driver or a passenger?	☐Driver	☐Passenger
Were you wearing your seatbelt?	☐Yes	☐No
Were you intoxicated?	☐Yes	☐No
Did your vehicle's airbags deploy?	☐Yes	☐No
Did you lose consciousness?	☐Yes	☐No

At the time of the accident, what parts of your head/body hit what parts of the inside of the vehicle: ___________

____

What symptoms (pain, stiffness, other) did you feel immediately after the accident? _________________________

____

What symptoms (pain, Stiffness, other) did you feel about 24 hours after the accident?______________________

____

About Medical Care You Received

Did you receive medical care for your injuries? ☐ Yes ☐ No

Were X-rays taken? ☐ Yes ☐ No - If yes, explain: _____________________________________

What was your diagnosis? ____

What treatment was provided? ____

What effect did the treatment have? ____

About Your Health History

Have you been in a motor vehicle collision prior to this most recent one?	☐Yes	☐ No
Do you have a history of headaches (more than once per month)?	☐ Yes	☐ No
Do you have a history of neck pain (more than once per month)?	☐ Yes	☐ No
Do you have a history of back pain (more than once per month)?	☐ Yes	☐ No
Have you seen a chiropractor before?	☐ Yes	☐ No

Injury Magnifiers

About Your Body at the Time of Impact

1. Did you have time to brace for impact? Yes No
2. Was your head or body turned to the right or left? Yes No
3. Was your head rest up and level with your head? Yes No
4. Was your car moving at the time of impact? Yes No
5. Were the roads wet outside? Yes No

Make model and year of **MY** vehicle:________________________________

Make model, and Year of **Other** vehicle:____________________________

For Office use only

Weight of **MY** vehicle: ____

Weight of the **OTHER** vehicle: ____________________________________

Safety rating of my vehicle: _______________________________________

Patient Signature_____________________________________ Date_______________________

Guardian Signature___________________________________ Date_______________________