Rhae Majerowski, DC

Accident Questionnaire

Name _____ Today's Date _____

Date of Accident: _____ Location of Accident: _____

Questions about the accident circumstances:
Year and make of the vehicle you were riding in: _____
Number of other vehicles involved: ____ Year and make of other vehicle(s): _____
_____
Monetary damage to your vehicle: $_____ Monetary damage to other vehicles: $_____
Speed of vehicles at impact: ☐ your vehicle ____mph ☐ vehicle #2____mph ☐ vehicle #3 ___mph
Were you the driver or passenger? ☐ Driver ☐ Passenger
If you were a passenger, where were you seated?
☐ front seat, passenger's side ☐ rear seat, driver's side ☐ rear seat, passenger's side
Were you wearing a seat belt at the time? ☐ Yes ☐ No
Was your vehicle moving or stopped? ☐ Moving ☐ Stopped
Did your vehicle strike another vehicle? ☐ Yes ☐ No
Did another vehicle strike yours? ☐ Yes ☐ No
Where was your vehicle hit? ☐ in the front ☐ in the rear ☐ on the driver's side ☐ on the passenger's side
Describe the impact: _____
If your vehicle had air bags, did they deploy? ☐ Yes ☐ No
What were the road conditions? ☐ dry ☐ wet ☐ icy ☐ snow-packed ☐ other
How far did your car move **after** impact? Car lengths _____ Feet

Questions about your circumstances at impact:
Did you see the impact? ☐ Yes ☐ No If yes, did you brace yourself before impact? ☐ Yes ☐ No
Where were you looking? ☐ Forward ☐ Upward ☐ Down ☐ to the left ☐ to the right
Were you looking in a mirror? ☐ Yes ☐ No If yes, please describe: _____
What was your body position at time of impact? ☐ Neutral ☐ Forward ☐ Rotated (right / left)
Which way were you turning? ☐ to the left ☐ to the right ☐ not turning at all
Did you strike another object? ☐ wheel ☐ dash ☐ window ☐ other (describe) _____
Did you experience any of the following at the time of impact?
☐ cuts ☐ bruises ☐ abrasions ☐ dislocations
☐ bumps / where: _____ ☐ immediate dizziness
☐ nausea ☐ vision problems ☐ altered consciousness
☐ immediate head pain ☐ discharge from your ears or nose
☐ immediate pain / where: _____
☐ loss of consciousness / how long: _____

Questions about your circumstances after the accident:
Were you able to get out of the vehicle and walk on your own? ☐ Yes ☐ No
Was your car drivable from the scene of the accident? ☐ Yes ☐ No
Did you go to the hospital, home or return to work? ☐ Hospital ☐ Home ☐ Work
Who was at fault for this accident? _____
Did police write any tickets? ☐ Yes ☐ No To whom: _____
If you went to a hospital, did you stay overnight? ☐ Yes ☐ No
If you went to the hospital, were any x-rays taken? ☐ Yes ☐ No
If x-rays were taken, what areas of your body were x-rayed? _____
Were you instructed on any of the following? ☐ use ice ☐ use heat ☐ other _____
How did you feel that night: ☐ restless ☐ in pain ☐ stiff ☐ sore ☐ fine
How did you feel the next day: ☐ better ☐ same ☐ worse
Have your complaints kept you from doing anything? ☐ Yes ☐ No What: _____
_____