



# Staci Talan, D.C., I.D.E., Q.M.E.

Chiropractor \* Industrial Disability Examiner (IDE) \* Qualified Medical Examiner (QME)

39809 Paseo Padre Parkway, Fremont, CA 94538 \* TEL: 510-657-1234 \* FAX: 510-657-1233

## AUTOMOBILE ACCIDENT QUESTIONNAIRE

### PATIENT INFORMATION

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

1. What was the date of the accident? \_\_\_\_\_ What time did the accident occur? \_\_\_\_\_
2. Describe the accident in your own words? \_\_\_\_\_  
\_\_\_\_\_

### IMPACT/ACCIDENT SITE

1. How many vehicles were involved in the accident? \_\_\_\_\_
2. What was the estimated damage to the vehicle you were in? \_\_\_\_\_
3. What city and state did the accident occur in? \_\_\_\_\_
4. What street or intersection were you on when the accident occurred? \_\_\_\_\_
5. What direction were you traveling in? \_\_\_\_\_
6. What type of impact was the auto accident? \_\_\_\_\_
7. Did your vehicle hit anything after the accident?  no  yes  
explain \_\_\_\_\_
8. Where were you sitting in the vehicle during the accident? \_\_\_\_\_
9. Did you know the accident was coming? \_\_\_\_\_
10. At the time of the impact how fast was your vehicle moving? \_\_\_\_\_
11. At the time of impact, how fast was the other vehicle moving? \_\_\_\_\_
12. How many passengers were in your vehicle? \_\_\_\_\_
13. During and after the crash what happened to you vehicle? (check all that apply)
 

<input type="checkbox"/> kept going straight	<input type="checkbox"/> spun around
<input type="checkbox"/> kept going straight hitting a care in front	<input type="checkbox"/> spun around and hit a stationary object
<input type="checkbox"/> was hit by another vehicle	<input type="checkbox"/> hit a stationary object

### VEHICLE

1. What type of vehicle were you in? \_\_\_\_\_
2. What type of vehicle impacted yours? \_\_\_\_\_
3. .What kind of headrest was in your vehicle?
 

<input type="checkbox"/> movable fixed headrest	<input type="checkbox"/> non-moveable fixed headrest	<input type="checkbox"/> no headrest
---	--	--------------------------------------
4. Where was the headrest positioned on your head? \_\_\_\_\_
5. Did you have your seatbelt on during the accident?  no  yes
6. Did you slide out of your seatbelt during the accident?  no  yes
7. What was damaged in your vehicle? (check all that applies)

<input type="checkbox"/> windshield	<input type="checkbox"/> side window	<input type="checkbox"/> trunk	<input type="checkbox"/> mirror
<input type="checkbox"/> steering wheel	<input type="checkbox"/> rear window	<input type="checkbox"/> front left door	<input type="checkbox"/> knee bolster
<input type="checkbox"/> dashboard	<input type="checkbox"/> rear bumper	<input type="checkbox"/> front right door	<input type="checkbox"/> back right door
<input type="checkbox"/> seat frame	<input type="checkbox"/> front bumper	<input type="checkbox"/> back left door	<input type="checkbox"/> completely totaled

8. Choose the items that dented inward
 

<input type="checkbox"/> floorboards	<input type="checkbox"/> side doors	<input type="checkbox"/> dashboard
--------------------------------------	-------------------------------------	------------------------------------
9. Choose the doors that would not open as a result of the accident
 

<input type="checkbox"/> front left	<input type="checkbox"/> front right	<input type="checkbox"/> rear left	<input type="checkbox"/> rear right
-------------------------------------	--------------------------------------	------------------------------------	-------------------------------------

### POLICE

1. Did the police come to the accident site?  no  yes
2. Where there any witness?  no  yes
3. Was a police report filed?  no  yes
4. Was a traffic violation issued?  no  yes  
If so to whom? \_\_\_\_\_

### PATIENT CONDITION

1. Did you lose consciousness during the accident?  no  yes
2. How was you head positioned during the accident? \_\_\_\_\_
3. How was your torso positioned during the accident? \_\_\_\_\_



**Staci Talan, D.C., I.D.E., Q.M.E.**

Chiropractor \* Industrial Disability Examiner (IDE) \* Qualified Medical Examiner (QME)

39809 Paseo Padre Parkway, Fremont, CA 94538 \* TEL: 510-657-1234 \* FAX: 510-657-1233

4. How were your hands positioned during the accident? \_\_\_\_\_
5. Did your face hit anything during the accident?  
 no  yes explain \_\_\_\_\_
6. Did your head hit anything during the accident?  
 no  yes explain \_\_\_\_\_
7. Did your shoulders hit anything during the accident?  
 no  yes explain \_\_\_\_\_
8. Did your neck hit anything during the accident?  
 no  yes explain \_\_\_\_\_
9. Did your chest hit anything during the accident?  
 no  yes explain \_\_\_\_\_
10. Did your hips hit anything during the accident?  
 no  yes explain \_\_\_\_\_
11. Did your knees hit anything during the accident?  
 no  yes explain \_\_\_\_\_

**SYMPTOMS**

1. Have you been able to work since the injury?  yes  no How many work days have you missed? \_\_\_\_\_
2. Prior to the accident were you able to work on an equal basis with others your age?  yes  no
3. If you have had any of the following symptoms since you injury please check:

<input type="checkbox"/> Arm/Shoulder Pain	<input type="checkbox"/> Feet/Toe numbness	<input type="checkbox"/> Neck Pain
<input type="checkbox"/> Back Pain	<input type="checkbox"/> Hand/Finger numbness	<input type="checkbox"/> Neck Stiffness
<input type="checkbox"/> Back Stiffness	<input type="checkbox"/> Headaches	<input type="checkbox"/> Shortness of Breath
<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Irritability	<input type="checkbox"/> Sleep Difficulty
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Jaw Problems	<input type="checkbox"/> Stomach Upset
<input type="checkbox"/> Leg Pain	<input type="checkbox"/> Ear Buzzing	<input type="checkbox"/> Tension
<input type="checkbox"/> Memory Loss	<input type="checkbox"/> Ear Ringing	<input type="checkbox"/> Vision Blurred
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Nausea	

4. Is this condition getting progressively worse?  yes  no  unknown
5. Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) \_\_\_\_\_
6. Type of pain:

<input type="checkbox"/> sharp	<input type="checkbox"/> dull	<input type="checkbox"/> throbbing	<input type="checkbox"/> numbness
<input type="checkbox"/> aching	<input type="checkbox"/> shooting	<input type="checkbox"/> burning	<input type="checkbox"/> tingling
<input type="checkbox"/> cramps	<input type="checkbox"/> stiffness	<input type="checkbox"/> swelling	<input type="checkbox"/> other _____

7. How often do you have this pain? \_\_\_\_\_
8. Is it constant or does it come and go? \_\_\_\_\_
9. Does it interfere with:  Work  Sleep  Daily Routine  Recreation
10. Movement that are painful to perform:  Sitting  Standing  Walking  Bending  Lying Down

**TREATMENT**

1. Did you go to the hospital?  yes  no if not skip questions 38-43
2. How did you get to the hospital? \_\_\_\_\_
3. What was the name of the hospital? \_\_\_\_\_
4. Were you hospitalized?  no  yes how long? \_\_\_\_\_
5. Circle what you were prescribed in the hospital/emergency room  
 pain medication  muscle relaxers  neck brace  other explain \_\_\_\_\_
6. Did you receive any stitches for any cuts at the hospital  no  yes, where? \_\_\_\_\_
7. Were xrays taken in the hospital?  no  yes which areas were taken? \_\_\_\_\_

Patient signature: \_\_\_\_\_ Date: \_\_\_\_\_