



TIERNEY  
CHIROPRACTIC

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### Automobile Accident Questionnaire

Name: \_\_\_\_\_ Date of Injury: \_\_\_\_\_

**Type of Accident/Impact Location:**

- Head on: Left Right Straight
- Rear end: Left Right Straight
- Broadside collision ("T-Bone"): Left Right Front Mid Back
- Other \_\_\_\_\_

**Vehicle Status:**  Drivable  Towed/repairable  Totaled  Mirror(s) broken/bent  Seat beat broken  
**Police on scene?:**  Yes  No

**Details of impact:**

What time of day:  Day  Night  Dawn  Dusk Road Condition:  Dry  Damp  Wet Ice  
 Were you:  Driver  Passenger  Front Seat  Back Seat  Pedestrian  Bicyclist  
 Other:  Seat belt fastened  Seat Belt over shoulder  Airbag deployed  Braced for impact  
 Was the vehicle in motion prior to impact?  Yes  No If yes, how fast \_\_\_\_\_ mph  
 Were you able to apply brakes before impact?  Yes  No  
 Head position:  Left  Right  Straight  Head turned looking behind  
 Hand Position:  One on Wheel  Two on Wheel  Other \_\_\_\_\_  
 Sitting Position:  Knees left  Knees Right  Knees Straight  Feet up on dash  
 Were there other people in the vehicle with you:  Yes  No Wearing Glass?  Yes  No

**Head Movement:** Did You Hit Your Head:  Yes  No  
If yes, what did your head hit?  Rear head rest  Flying object  Windshield  Steering wheel  
 Door frame  Side window  Other \_\_\_\_\_

Were you knocked unconscious?  Yes  No If so, how long? \_\_\_\_\_

**Body Movement:** Did Your Body Hit Anything:  Yes  No If yes, which body part:  
 Knee  Leg  Ankle  Foot  Hip  Jaw  Shoulder  Elbow  Wrist  Hand

What did your body hit? \_\_\_\_\_

Did You Feel Your Body Go:  Forward and Back  Back and forward  Side to Side  Spinning  
Did your vehicle strike other objects or vehicles as a result of the accident?  Yes  No If Yes, Explain

**Symptoms from accident:**  Headache  Dizzy  Disoriented  Shock  Neck pain/stiff  Jaw pain  
 Back pain/stiff  Numbness/Tingling  Other \_\_\_\_\_

1<sup>st</sup> symptom appeared \_\_\_\_\_ (min or hrs). after accident

**After Accident:**

Went to \_\_\_\_\_ (location) on \_\_\_\_\_ (date/time)

Taken to this location by \_\_\_\_\_

Was any other doctor consulted after your accident?  Yes  No Whom? \_\_\_\_\_

What type of treatment/self-treatment did you receive/do? \_\_\_\_\_

Have you been working since the accident?:  Yes  No If yes, date returned to work: \_\_\_\_\_

Are your work activities restricted as a result of the accident?  Yes  No Work Days Missed: \_\_\_\_\_

What complaints in the involved area did you have prior to the accident? \_\_\_\_\_

**Insurance:** Insurance company: \_\_\_\_\_

Agent Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Policy and/or Claim Number: \_\_\_\_\_

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