

CAR CRASH QUESTIONNAIRE

Patient Name: _____ Date: _____

Street (location) where crash occurred: _____

City: _____ State: _____ Date of Crash: _____ AM PM

Police come to the scene? Yes No Was a police report made? Yes No Number of passengers in your vehicle _____

What is the estimated cost to repair your vehicle? \$ _____

DESCRIBE THE CRASH: _____

COLLISION DESCRIPTION: *Check all that apply to you. Were you involved in the following type of accident?*

- Single-car crash Two-vehicle crash Three or more vehicles Ran off road Hit guardrail/tree/wall
 Rear-end crash Side crash Head-on crash Rollover

INDICATE YOUR SEATING POSITION: Driver Front passenger Left rear passenger Right rear passenger

DESCRIBE THE VEHICLE YOU WERE IN: Make _____ Model year _____

- Small car Mid-sized car Van Full-sized car Pick-up truck/sport utility Large truck, bus, or semi-truck

If *not* in your own auto: Name of owner: _____

Relationship: _____

Owners Insurance Company: _____

DESCRIBE THE OTHER VEHICLE: Make _____ Model year _____

- Small car Mid-sized car Van Full-sized car Pick-up truck/sport utility Large truck, bus, or semi-truck

ESTIMATED CRASH SPEEDS:

Estimate how fast your vehicle was moving at the time of crash. _____ mph Unknown

Estimate how fast the other vehicle was moving at the time of crash. _____ mph Unknown

AT THE TIME OF IMPACT YOUR VEHICLE WAS: Slowing down Stopped Gaining speed Moving at a steady speed

AT THE TIME OF IMPACT THE OTHER VEHICLE WAS: Slowing down Stopped Gaining speed Moving at a steady speed

DURING AND AFTER THE CRASH, YOUR VEHICLE:

- Kept going straight, not hitting anything Kept going straight, hitting car in front Was hit by another car
 Spun around, not hitting anything Spun around, hitting another car Spun around, hitting another object

SEATBELT USAGE AND STEERING WHEEL HAND PLACEMENT:

Were you wearing a seatbelt? Yes No Lap and shoulder strap? Yes No Lap belt only? Yes No

Were you holding onto the steering wheel? Yes No

REAR END COLLISION ONLY:

My seat had moveable/adjustable head restraints: Yes No

My seat had fixed head restraints: Yes No My seat had head restraints: Yes No

AWARENESS AND BODY POSITION DESCRIPTIONS: *Check all areas that apply to you.*

- You were unaware of the impending collision. You *did* not see or hear brakes prior to impact.
 You were aware of the impending crash and relaxed before the collision.
 You were aware of the impending crash and braced yourself.
 Your head, torso, and head were facing straight ahead.
 You had your head and/or torso turned at the time of collision. Turned left Turned right
 You were leaning forward at the time of impact resulting in a gap between your body and seatback.
 You were seated/positioned normally.

Please complete the reverse side

Were you knocked unconscious? Yes No List any broken bones? _____

Taken to the emergency room? Yes No Name of ER _____ City _____

How soon did you first notice any pain-soreness after your injury? Immediately ___ Hours later ___ Days later

Did you have any cuts or lacerations? Yes No List: _____

Were you hospitalized? Yes No Name of hospital _____ City _____

I was charged as being "at fault" in the crash. Yes No

INDICATE IF YOUR BODY HIT SOMETHING OR WAS HIT BY ANY OF THE FOLLOWING: Check all areas that apply to you.

- | | |
|--|---|
| <input type="checkbox"/> Head Hit: _____ | <input type="checkbox"/> Face Hit: _____ |
| <input type="checkbox"/> Right Shoulder Hit: _____ | <input type="checkbox"/> Left Shoulder Hit: _____ |
| <input type="checkbox"/> Right Arm/Hand Hit: _____ | <input type="checkbox"/> Left Arm/Hand Hit: _____ |
| <input type="checkbox"/> Right Side Chest Hit: _____ | <input type="checkbox"/> Left Side chest Hit: _____ |
| <input type="checkbox"/> Front Chest wall Hit: _____ | <input type="checkbox"/> Abdomen Hit: _____ |
| <input type="checkbox"/> Right Hip Hit: _____ | <input type="checkbox"/> Left Hip Hit: _____ |
| <input type="checkbox"/> Right Knee Hit: _____ | <input type="checkbox"/> Left Knee Hit: _____ |
| <input type="checkbox"/> Right Leg Hit: _____ | <input type="checkbox"/> Left Leg Hit: _____ |
| <input type="checkbox"/> Right Foot Hit: _____ | <input type="checkbox"/> Left Foot Hit: _____ |

INSURANCE INFORMATION

Florida State Law: Florida is a "NO FAULT" insurance state and by law you **must** bill bodily injury expenses to your own insurance, regardless of who was listed as at fault. If you or anyone in your household has auto insurance, you **must** file with that company regardless of who is in the wrong.

- I do not own an automobile. I own an automobile but do **not** have insurance coverage on it.

Your Insurance Company: _____

Name of insured: _____ Relationship: _____

Ph# _____ Claim# _____

I have made an injury report to my insurance company: Yes No

At Fault Insurance Company: _____ PH# _____

Claim# _____ Name of insured: _____

In order to provide necessary documentation of your injuries, please advise if you are represented by an attorney for this accident?

Name of Attorney: _____ PH# _____

Address: _____

If you are not represented by an attorney, are planning on getting an attorney? Yes No

Signature