Lee Chiropractic
3500 Barranca Parkway, Suite 310
Irvine, CA 92604

Auto Accident Questionnaire

Patient Name: _____ Date: _____

1. What was the date of the accident?_____

2. What time did the accident occur?_____

3. How many vehicles were involved in the accident?_____

4. What was the estimated damage to the vehicle you were in? _____

5. What state did the accident occur in? _____

6. What city did the accident occur in? _____

7. What street or intersection were you on when the accident occurred? _____

8. What direction were you traveling in? _____

9. What type of impact was the auto accident? _____

10. Did your vehicle hit anything after the accident? ☐ no ☐ yes, please describe _____

_____

11. Where were you sitting in the vehicle during the accident? _____

12. Did you know the accident was coming?_____

13. What type of vehicle were you in? _____

14. What type of vehicle impacted yours? _____

15. At the time of the impact, how fast was your vehicle moving? _____

16. At the time of impact, how fast was the other vehicle moving? _____

17. During and after the crash what happened to your vehicle? (check all that apply)

☐ kept going straight
☐ kept going straight hitting a car in front
☐ was hit by another vehicle
☐ spun around
☐ spun around and hit a stationary object
☐ hit a stationary object

18. Did you lose consciousness during the accident? ☐ yes ☐ no

19. How was your head positioned during the accident? _____

20. How was your torso positioned during the accident? _____

21. How were your hands positioned during the accident? _____

22. Did your head hit anything during the accident? ☐ no ☐ yes, please describe _____

_____

23. Did your face hit anything during the accident? ☐ no ☐ yes, please describe _____

_____

24. Did your shoulders hit anything during the accident? ☐ no ☐ yes, please describe _____

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25. Did your neck hit anything during the accident? ☐ no ☐ yes, please describe _____

26. Did your chest hit anything during the accident? ☐ no ☐ yes, please describe _____

27. Did your hips hit anything during the accident? ☐ no ☐ yes, please describe _____

28. Did your knees hit anything during the accident? ☐ no ☐ yes, please describe _____

29. Did your feet hit anything during the accident? ☐ no ☐ yes, please describe _____

30. What kind of headrest was in your vehicle?
☐ movable fixed headrest ☐ non-movable fixed headrest ☐ no headrest

31. Where was the headrest positioned on your head? _____

32. Did you have your seatbelt on during the accident? ☐ no ☐ yes

33. Did you slide out of your seatbelt during the accident? ☐ no ☐ yes

34. What was damaged in your vehicle? (Check all that apply)

☐ windshield	☐ side window	☐ trunk	☐ mirror
☐ steering wheel	☐ rear window	☐ front left door	☐ knee bolster
☐ dashboard	☐ rear bumper	☐ front right door	☐ back right door
☐ seat frame	☐ front bumper	☐ back left door	☐ completely totaled

35. Choose the items that dented inward
☐ floorboards ☐ side door ☐ dashboard

36. Choose the doors that would not open as a result of the accident
☐ front left ☐ front right ☐ rear left ☐ rear right

37. Did you go to the hospital? If no, why and do not answer 38-43
_____

38. How did get to the hospital? _____

39. What was the name of the hospital? _____

40. Were you hospitalized over night? ☐ no ☐ yes, how long _____

41. Circle what you were prescribed at the hospital:
☐ pain medication ☐ muscle relaxors ☐ neck brace

42. Did you receive any stitches for any cuts at the hospital? ☐ no ☐ yes, where _____

43. Were x rays taken at the hospital? ☐ no ☐ yes, which area was taken? _____