

# ASCC AUTOMOBILE ACCIDENT QUESTIONNAIRE

Patient's Name: \_\_\_\_\_

Today's Date: \_\_\_\_\_

Date of Accident: \_\_\_\_\_

## THE FOLLOWING QUESTIONS PERTAIN TO YOU AND THE VEHICLE YOU WERE IN:

### Vehicle type:

- Car                       Pickup  
 Van                         Truck  
 Station Wagon        Bus  
 Other \_\_\_\_\_

### Vehicle size:

- Subcompact        Full-size  
 Compact             Mini  
 Mid-size             Light  
 Heavy                 Other \_\_\_\_\_

### Your position in the vehicle:

- Driver  
 Passenger        Location-----  Left                       Middle                       Right  
 Other \_\_\_\_\_        Front Passenger     Rear Passenger     Third Seat (rear)

### Speed of your vehicle:

- Stopped             Moving Moderately  
 Parked              Moving Fast  
 Slowing             Moving at apprx \_\_\_\_MPH  
 Moving Slowly

### Why Vehicle was slowed or stopped:

- Traffic Signal     Parking  
 Pedestrian        Traffic  
 Stop Sign         Busy Intersection

### Collision Type:

- Driver Side Impact        Head On Collision  
 Passenger Side Impact    Rear Impact  
 Front Impact               Pedestrian Incident

## THE FOLLOWING QUESTIONS CONCERN THE OTHER VEHICLE INVOLVED IN THE ACCIDENT:

### Vehicle type:

- Car     Pickup  
 Van     Truck  
 Station Wagon  
 Other \_\_\_\_\_

### Vehicle size:

- Subcompact     Full-size  
 Compact         Mini  
 Bus                Mid-size         Light  
 Heavy             Other \_\_\_\_\_

## CONDITIONS AT THE TIME OF THE ACCIDENT:

### Time of day:

- Full daylight  
 Dawn  
 Dusk  
 Night

### Road Conditions:

- Dry  
 Damp  
 Wet  
 Snow covered  
 Ice covered  
 Patchy Ice/Snow

### Visibility:

- Excellent  
 Good  
 Fair  
 Poor

### Visibility compromised by:

- Brightness  
 Darkness  
 Rain  
 Snow  
 Fog  
 Traffic

## THE FOLLOWING QUESTIONS CONCERN THE MOMENT OF IMPACT OF THE ACCIDENT:

### Were you... \_\_\_\_\_

- Totally unaware that the accident was impending  
 Aware that the accident was impending  
 Aware that the accident was impending and braced for it

### Restraints: (check all that apply)

- Seat belt  
 Shoulder harness  
 No restraints

**If you were the driver of the vehicle, was your foot on the brake pedal?**  Yes  No  Knocked off by impact

### Was the air bag deployed? \_\_\_\_\_

- Car not equipped with air bag  
 Air bag deployed  
 Air bag not deployed

### What position was YOUR headrest in?

- High position  
 Middle position  
 Low position

**Position of YOUR head at time of impact?**

- Facing straight ahead
- Tilted forward
- Rotated to the left
- Rotated to the right

**Was your head thrown...?**

- Backward and then forward
- Forward then backward
- To the left       To the left then the right
- To the right       To the right, then the left

**Position of Your body at time of impact?**

- Straight
- Tilted forward
- Rotated to the left
- Rotated to the right

**Was your body thrown...?**

- Backward and then forward
- Forward then backward
- To the left       To the left then the right
- To the right       To the right, then the left
- Across the vehicle
- Outside the vehicle       Under the vehicle

**Damage to vehicle YOU were in:**

- Incurred minimal damage
- Incurred moderate damage
- Incurred severe damage
- Was totalled
- Not known

**Citations:**

- None issued
- Yourself
- Driver of vehicle patient was a passenger of
- Driver of other vehicle
- Not sure

*AS A RESULT OF THE FORCE OF THE COLLISION, WHICH OBJECTS IN THE VEHICLE DID YOUR BODY STRIKE?*

**Head**

- Steering wheel
- Dashboard
- Windshield
- Armrest
- Headrest
- Rear view mirror
- Left door

- Right door
- Left window
- Right window
- Console
- Gear shift
- Front seat
- Backseat

**Left Arm**

- Steering wheel
- Dashboard
- Windshield
- Armrest
- Headrest
- Rear view mirror
- Left door

- Right door
- Left window
- Right window
- Console
- Gear shift
- Front seat
- Backseat

**Right Arm**

- Steering wheel
- Dashboard
- Windshield
- Armrest
- Headrest
- Rear view mirror
- Left door

- Right door
- Left window
- Right window
- Console
- Gear shift
- Front seat
- Backseat

**Torso**

- Steering wheel
- Dashboard
- Windshield
- Armrest
- Headrest
- Rear view mirror
- Left door

- Right door
- Left window
- Right window
- Console
- Gear shift
- Front seat
- Backseat

**Left Leg**

- Steering wheel
- Dashboard
- Windshield
- Armrest
- Headrest
- Rear view mirror
- Left door

- Right door
- Left window
- Right window
- Console
- Gear shift
- Front seat
- Backseat

**Right Leg**

- Steering wheel
- Dashboard
- Windshield
- Armrest
- Headrest
- Rear view mirror
- Left door

- Right door
- Left window
- Right window
- Console
- Gear shift
- Front seat
- Backseat

THE FOLLOWING QUESTIONS CONCERN THE TIME PERIOD IMMEDIATELY FOLLOWING THE ACCIDENT:

**Did you lose consciousness?**

- Yes
- No

**Immediately following the accident, did you feel...?**

- Dizzy
- Dazed
- Disoriented
- Weak
- Nervous
- Nauseated

**Were you able to walk unaided?**

- Yes
- No

**Where did you go...?**

- Drove home
- Was driven home
- Drove to hospital
- Was driven to hospital
- Taken to hospital via ambulance
- Drove to work
- Was driven to work
- Drove to school
- Was driven to school

**Next day discomfort...? accident?**

- increased
- decreased
- same

- Yes
- No

**Did your major complaints exist before the**

**In what areas did you IMMEDIATELY feel pain?**

- |                                     |                                 |                               |                                |       |                               |                                |
|-------------------------------------|---------------------------------|-------------------------------|--------------------------------|-------|-------------------------------|--------------------------------|
| <input type="checkbox"/> Head       | Shoulder                        | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Hip   | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Neck       | Arm                             | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Thigh | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Upper back | Elbow                           | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Knee  | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Mid back   | Wrist                           | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Calf  | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Ribs       | Hand                            | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Ankle | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Chest      | Fingers                         | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Foot  | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Abdomen    | Buttock                         | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Toes  | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Low Back   | <input type="checkbox"/> Pelvis |                               |                                |       |                               |                                |

**In what areas did you experience lacerations (cuts)?**

- |                                     |                                 |                               |                                |       |                               |                                |
|-------------------------------------|---------------------------------|-------------------------------|--------------------------------|-------|-------------------------------|--------------------------------|
| <input type="checkbox"/> Head       | Shoulder                        | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Hip   | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Neck       | Arm                             | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Thigh | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
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| <input type="checkbox"/> Low Back   | <input type="checkbox"/> Pelvis |                               |                                |       |                               |                                |

**At the hospital, what areas were x-rayed?**

- |                                     |                                 |                               |                                |       |                               |                                |
|-------------------------------------|---------------------------------|-------------------------------|--------------------------------|-------|-------------------------------|--------------------------------|
| <input type="checkbox"/> Head       | Shoulder                        | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Hip   | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
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| <input type="checkbox"/> Low Back   | <input type="checkbox"/> Pelvis |                               |                                |       |                               |                                |

**Where did you experience pain on the day FOLLOWING the accident?**

- |                                     |                                 |                               |                                |       |                               |                                |
|-------------------------------------|---------------------------------|-------------------------------|--------------------------------|-------|-------------------------------|--------------------------------|
| <input type="checkbox"/> Head       | Shoulder                        | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Hip   | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
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| <input type="checkbox"/> Low Back   | <input type="checkbox"/> Pelvis |                               |                                |       |                               |                                |

Patient's Signature: \_\_\_\_\_