Hanson Chiropractic

Automobile Crash Questionnaire

Name: _____

1. Today's Date_____

2. What is the date of the accident?_____

3. In your own words, please describe what happened.

_____

_____

_____

_____

4. Were you wearing a seatbelt at the time of impact?
   - ❑ **Restrained (Yes)**
   - ❑ **Unrestrained (No)**

5. Did the airbag deploy?
   - ❑ **Did**
   - ❑ **Did not**

6. Where were you looking at the time of the impact?
   - ❑ **Head Straight**
   - ❑ **Head Down**
   - ❑ **To The Left**
   - ❑ **To The Right**
   - ❑ **Over the Left Shoulder**
   - ❑ **Over the Right Shoulder**
   - ❑ **Unknown**

7. Did your body contact the interior of vehicle?
   - ❑ **Did**
   - ❑ **Did Not**

8. What body part impacted the inside of the vehicle?
   - ❑ **Any body Part _____**
     - o **Left**
     - o **Right**
   - ❑ **Head**
   - ❑ **Chest**
   - ❑ **Shoulder**
   - ❑ **Arm**
   - ❑ **Knee**
   - ❑ **Leg**
   - ❑ **Foot**

9. What part of the vehicle did you impact?
   - ❑ **Any Interior part**
     - o **Left**
     - o **Right**
   - ❑ **Airbag**
   - ❑ **Dashboard**
   - ❑ **Windshield**
   - ❑ **Steering Wheel**
   - ❑ **Door**
   - ❑ **Window**
   - ❑ **Arm rest**
   - ❑ **Seat**
   - ❑ **Head Rest**

10. What part of your vehicle was impacted?
   - ❑ **Left**
   - ❑ **Right**
   - ❑ **Front**
   - ❑ **Rear**
   - ❑ **Side**
   - ❑ **Unknown**
   - ❑ **Head On**

11. How was your vehicle moving at the time of impact?
   - ❑ **Stopped**
   - ❑ **Backing Up**
   - ❑ **Movement Unknown**
   - ❑ **Moving Forward**
   - ❑ **Turning Left**
   - ❑ **Turning Right**
   - ❑ **Speed Unknown**
   - ❑ **Less than 15 MPH**
   - ❑ **Up to 25 MPH**
   - ❑ **Up to 40 MPH**
   - ❑ **Up to 65 MPH**
   - ❑ **Over 65 MPH**

12. How much damage was there to your vehicle?
   - ❑ **Sustained no visible damage**
   - ❑ **Sustained slight visible damage**
   - ❑ **Sustained Moderate Visible damage**
   - ❑ **Sustained Heavy visible damage**
   - ❑ **Was totaled**

13. What part of the other vehicle was impacted?
   - ❑ **Left**
   - ❑ **Right**
   - ❑ **Front**
   - ❑ **Rear**
   - ❑ **Side**
   - ❑ **Unknown**
   - ❑ **Head On**

14. What was the other vehicle doing at the time of impact?
   - ❑ **Stopped**
   - ❑ **Backing Up**
   - ❑ **Movement Unknown**
   - ❑ **Moving Forward**
   - ❑ **Turning Left**
   - ❑ **Turning Right**
   - ❑ **Speed Unknown**
   - ❑ **Less than 15 MPH**
   - ❑ **Up to 25 MPH**
   - ❑ **Up to 40 MPH**
   - ❑ **Up to 65 MPH**
   - ❑ **Over 65 MPH**

15. Did your vehicle need to be towed away?
- ❑ **Was**
- ❑ **Has Not**

16. Were the police called to the scene? (Mark all that apply)
- ❑ **Were at the scene**
- ❑ **Were not at the scene**

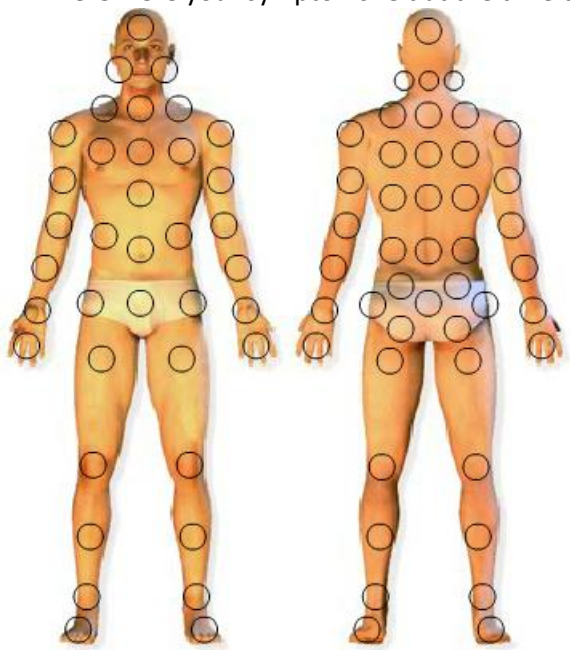
- ❑ **Patient was cited**
- ❑ **Other driver was cited**
- ❑ **No citations were issued**
- ❑ **Patient was arrested**
- ❑ **Other driver was arrested**

17. Was the Accident reported?
- ❑ Was
- ❑ Was not

18. Was Emergency Medical Services at the Scene?
- ❑ **Was**
- ❑ **Was not**

19. Were you transported to the Hospital?
- ❑ **Was transported to the Hospital**
- ❑ **Denied transport**
- ❑ **Was driven to the hospital**
- ❑ **Continued on with activities**
- ❑ **Drove home**
- ❑ **Arranged for a ride home**

20. Where were your symptoms felt at the time of the accident?



21. Describe the discomfort felt at the time of the accident: (check all that apply)
    - ❑ **Dull**
    - ❑ **Sharp**
    - ❑ **Shooting**
    - ❑ **Tightness/ stiffness**
    - ❑ **Tingling**
    - ❑ **Numbness**
    - ❑ **Nausea**
    - ❑ **Heart palpitations**
    - ❑ **Anxiety / panic**
    - ❑ **Depression**
    - ❑ **General Malaise**
    - ❑ **Fatigue**

22. What additional Symptoms did you notice?

    - ❑ **None**
    - ❑ **None reported**
    - ❑ **Anxiety**
    - ❑ **Breathing difficulty**
    - ❑ **Chest pain**
    - ❑ **Depression**
    - ❑ **Disbelief**
    - ❑ **Dizziness**
    - ❑ **Exhaustion**
    - ❑ **Fascial pain**
    - ❑ **Genital pain**
    - ❑ **Gluteal pain**
    - ❑ **Headaches**
    - ❑ **Irritability**
    - ❑ **Loss of appetite**
    - ❑ **Low energy**
    - ❑ **Muscle spasm**
    - ❑ **Numbness and tingling**
    - ❑ **Rib pain**

Please sign to certify that the above information is true to the best of your knowledge.

X_____ ***Date:*** _____

Printed Name: _____

Relationship to Patient:_____