



MOTOR VEHICLE ACCIDENT QUESTIONNAIRE

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? if 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? (circle all that apply)
 - kept going straight - spun around
 - kept going straight hitting a car in front - spun around and hit a stationary object
 - was hit by another vehicle - 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_____

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? YES / NO

33. Did you slide out of your seatbelt during the accident? _____

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

- windshield - rear bumper - mirror

- steering wheel - front bumper - knee bolster

- dashboard - trunk - back right door

- seat frame - front left door - completely totaled

- side window - front right door

- rear window - back left door

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? _____

41. Circle what you were prescribed at the hospital

- pain medication - muscle relaxers - neck brace

42. Did you receive any stitches for any cuts at the hospital? _____

43. Were x rays taken at the hospital? If yes, which area was taken?
