Connecticut Spine & Rehab
Injury Relief Centers

Automobile Accident Questionnaire

Today's Date _____ Date of Injury _____ Location of Injury _____
(Connecticut, New York, Etc.)

Were you the driver or passenger? _____

Where were you seated in the car? _____

Were you wearing a seat belt? Y N

Mechanism of injury (rear impact, passenger side impact, driver side impact, front impact)? _____

Was there a secondary impact (another car, a curb or barrier, etc.)? _____

Were you prepared for the impact? Y N

Did you strike any part of your body on the interior of the car? (What and Where) _____

_____

Did you lose consciousness? Y N How long? _____

Were you attended to by an EMT? Y N

Were you taken to the hospital? Y N Which Hospital? _____

IF YES: By ambulance or other transportation? _____

Were x-rays performed? Y N What body areas? _____

Were you admitted over night? Y N

Were you given orthopedic supports or braces? Y N What type? _____

Were you given medications or prescriptions? Y N What type? _____

_____

What were your discharge instructions? (no work, rest, home care, follow-up, exercise, etc.) _____

_____

Have you had any other medical care since the injury? Y N

Doctor or clinic name _____

When consulted _____

Treatment: _____

Have you had any diagnostic tests since the accident? (MRI, CT Scan, Bone Scan, X-Ray, etc.)

_____

Have you had any previous accident or injuries? Y N When? _____

Have you missed days from work? Y N How many? _____