Active Life Chiropractic-6401 Douglas Ave. Suite 12- Urbandale, IA 50322
(515)278-0363
PATIENT AUTOMOBILE COLLISION QUESTIONAIRE

NAME: _____
Last First MI

Date of Accident: _____ **Time:** _____ AM/PM

Describe how the crash happened:

_____

_____

_____

_____

Describe the vehicle you were in:
Model year and make: _____
☐ Compact car ☐ Mid-sized car ☐ Full sized car
☐ S.U.V. / truck ☐ Mini-van / van ☐ Larger than 1-ton vehicle
Describe the other vehicle:
Model year and make: _____
☐ Compact car ☐ Mid-sized car ☐ Full sized car
☐ S.U.V. / truck ☐ Mini-van / van ☐ Larger than 1-ton vehicle
You were: ☐ Driver ☐ Front Passenger ☐ Back Passenger
Your vehicle was hit where? ☐ Rear ☐ Front ☐ Driver side ☐ Passenger side
Speed of your vehicle? ☐ Stopped ☐ Slow ☐ Moderate ☐ Fast Approx. _____ MPH
Speed of other vehicle? ☐ Stopped ☐ Slow ☐ Moderate ☐ Fast Approx. _____ MPH
Check ALL that apply to you during the crash:
☐ You were unaware of the impending collision
☐ You were aware of the impending collision and relaxed before the collision
☐ You were aware of the impending collision and braced yourself
☐ Your body, torso, and head were facing straight ahead
☐ You had your head and/or torso turned at time of collision
☐ Turned to left ☐ Turned to right
☐ You were wearing a seat belt
If yes, does your seat belt have a shoulder harness? ☐ Yes ☐ No
☐ You were holding onto the steering wheel at the time of impact
Indicate how your head restraint was positioned at time of crash:
☐ At the top of the back of your head
☐ Midway height of the back of your head
☐ Lower height of the back of your head
☐ Located at level of your neck or below
☐ Unsure
At the time of the accident, list what parts of your head or body hit your vehicle and where on the vehicle they hit:

_____

_____

Did you lose consciousness? ☐ Yes ☐ No If yes, for how long _____

Please describe how you felt:
Immediately after the accident:_____

Later that day:_____

The next day:_____

What are your present complaints and symptoms?_____

_____

_____

_____

_____

What treatment have you received since the accident? (List doctor, type of treatment, results)

_____

_____

Did you have any physical complaints before the accident?
☐ No ☐ Yes, describe

_____

_____

List all previous accidents (major & minor), including dates and types, as well as injuries.

_____

_____

Describe your employment and how much time you have lost from work due to the accident.

_____

_____

List any activity restrictions as result of this accident:

_____

_____

Any other pertinent information:_____

_____

After reading and filling out the above questionnaire, your signature will verify that the information is accurate.

Patient Signature: _____Date:_____