Rick L. DaSo, D.C.

12020 Seminole Blvd.
Largo, Florida 33778

AUTOMOBILE ACCIDENT QUESTIONNAIRE

Patient's Name: ______________________________ Today's Date: _______________

Date of Accident: ___________________ Have you retained an attorney? Y N

Briefly describe the accident: ____

____

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

Your position in the vehicle:

❑Driver
❑Passenger -------- Location-------- ❑Left ❑Middle ❑Right
❑Other __________________ ❑Front Passenger ❑Rear Passenger ❑Third Seat (rear)

Vehicle size:

❑Subcompact ❑Full-size
❑Compact ❑Mini
❑Mid-size ❑Light
❑Heavy ❑Other_________________

Vehicle type :

❑Car ❑Pickup
❑Van ❑Truck
❑Station Wagon ❑Bus
❑Other_________________

Speed of your vehicle:

❑Stopped ❑Moving Moderately
❑Parked ❑Moving Fast
❑Slowing ❑Moving at approx. ____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 size:

❑Car ❑Pickup
❑Van ❑Truck
❑Station Wagon
❑Other_________________

Vehicle type:

❑Subcompact ❑Full-size
❑Compact ❑Mini
❑Bus ❑Mid-size ❑Light
❑Heavy ❑Other__________________

CONDITIONS AT THE TIME OF THE ACCIDENT:

Time of day:	Visibility:	Visibility compromised by:
❑Full daylight	❑Excellent	❑Brightness
❑Dawn	❑Good	❑Darkness
❑Dusk	❑Fair	❑Rain
❑Night	❑Poor	❑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 and shoulder harness
- ❑Seat belt ❑Shoulder harness
- ❑No restraints

Was the air bag deployed?
- ❑Car not equipped with air bag
- ❑Air bag deployed
- ❑Air bag not deployed

What position was YOUR headrestraint 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

Did your body strike anything inside the vehicle? o Yes o No

If yes please explain:

____

Damage to vehicle YOU were in:
- ❑Incurred minimal damage
- ❑Incurred moderate damage
- ❑Incurred severe damage
- ❑Was totaled
- ❑Not known

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

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 ❑Weak
- ❑Dazed ❑Nervous
- ❑Disoriented ❑Nauseated

Were you able to walk unaided?
❑Yes
❑No

Where did you go...?
❑Drove home ❑Drove to work
❑Was driven home ❑Was driven to work
❑Drove to hospital ❑Drove to school
❑Was driven to hospital ❑Was driven to school
❑Taken to hospital via ambulance

Next day discomfort...?
❑Increased ❑decreased ❑same

Did your major complaints exist before the accident?
❑Yes ❑ No

In what areas did you IMMEDIATELY feel pain?

❑Head	Shoulder	❑Left	❑Right	Hip	❑Left	❑Right
❑Neck	Arm	❑Left	❑Right	Thigh	❑Left	❑Right
❑Upper Back	Elbow	❑Left	❑Right	Knee	❑Left	❑Right
❑Mid Back	Wrist	❑Left	❑Right	Calf	❑Left	❑Right
❑Ribs	Hand	❑Left	❑Right	Ankle	❑Left	❑Right
❑Chest	Fingers	❑Left	❑Right	Foot	❑Left	❑Right
❑Abdomen	Buttock	❑Left	❑Right	Toes	❑Left	❑Right
❑Low Back						
❑Pelvis						

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

❑Head	Shoulder	❑Left	❑Right	Hip	❑Left	❑Right
❑Neck	Arm	❑Left	❑Right	Thigh	❑Left	❑Right
❑Upper Back	Elbow	❑Left	❑Right	Knee	❑Left	❑Right
❑Mid Back	Wrist	❑Left	❑Right	Calf	❑Left	❑Right
❑Ribs	Hand	❑Left	❑Right	Ankle	❑Left	❑Right
❑Chest	Fingers	❑Left	❑Right	Foot	❑Left	❑Right
❑Abdomen	Buttock	❑Left	❑Right	Toes	❑Left	❑Right
❑ Low Back						
❑Pelvis						

Please list others that you have seen or have treated you for this injury:

Hospital / ER ____

Doctor(s): ____

Others: ____

Has this injury restricted your work? oYes o No ______________________________

____

Before this accident were you able to work on an equal basis with others your age? oYes oNo

Patient's Signature: ______________________________ Date: ____________