



Chino Office 13801 Roswell Ave, #F Chino, Ca 91710 Office 909-464-2008 Fax 909-287-7705	Upland Office 886 W. Foothill Blvd, # E Upland, Ca 91786 Office 909-946-2673 909-946-1872	Glendora Office 230 N. Glendora Ave. Glendora, Ca 91741 Office 626-914-5881 Fax 626-914-0169
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Auto Accident Questionnaire

Patient Name: _____ Date: _____

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? ☹ no ☺ 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? (check 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 _____



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24. Did your shoulders hit anything during the accident? no yes, please describe _____

5. 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? no yes

33. Did you slide out of your seatbelt during the accident? no yes

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

- windshield side window trunk mirror
- steering wheel rear window front left door knee bolster
- dashboard rear bumper front right door back right door
- seat frame front bumper back left door completely totaled

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



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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? no yes, how long _____

41. Circle what you were prescribed at the hospital:

pain medication muscle relaxors neck brace

42. Did you receive any stitches for any cuts at the hospital? no yes, where _____

43. Were x rays taken at the hospital? no yes, which area was taken? _____