WALL FAMILY CHIROPRACTIC CENTER
Dr. Michael L. Wall, D.C.
13412 Pacific Avenue
Office: (253) 531-5242 Tacoma, WA, 98444 Fax: 253-537-7293

Vehicle Accident Questionnaire

Name:_____Date:_____

1. What was the date of the collision? _____
2. What time did the collision occur? _____
3. How many vehicles were involved in the collision? _____
4. What was the estimated damage to the vehicle you were in? $_____

   _____Totaled____or_____Unknown
5. What street or intersection were you on when the collision occurred? _____

   _____

   _
6. What direction were you traveling in? _____
7. What city did the collision occur in? _____
8. What state did the collision occur in? _____
9. What type of impact was the auto collision? Vehicle was rear-ended

   Vehicle hit another vehicle from behind Vehicle was hit on driver's side

   Vehicle was hit on passenger's side Other:_____
10. What did your vehicle do immediately after the accident?
11. Did your vehicle hit anything after the collision? If yes, please describe. _____

    _____

    _

    Hit a guardrail Hit a tree Rolled over Was run off the road
12. Where were you sitting in the vehicle during the collision? Driver Front passenger

    Rear left passenger Rear right passenger Rear passenger

13. **Did you know the collision was coming?** You were unaware of the impending collision

Aware of the collision and relaxed or Aware of the impending collision and braced yourself

14. **What type of vehicle were you in?** Subcompact car a compact car a mid-size car

a full-sized car a truck a SUV a minivan a van

a larger than one ton vehicle Other:_____

15. **What type of vehicle impacted yours?** _____

16. **At the time of the impact, how fast was your vehicle moving?** _____**mph**

slowing down stopped gaining speed moving at a steady speed

17. **At the time of impact, how fast was the other vehicle moving?** _____**mph**

slowing down stopped gaining speed moving at a steady speed

18. **During and after the crash, what happened to your vehicle? (Circle all that apply)**

Kept going straight Kept going straight hitting a car in front Spun around

Was hit by another vehicle Spun around and hit a stationary object Hit a stationary object

19. **Did you lose consciousness during the collision?** Yes No

20. How was your **head** positioned during the collision? _____

21. How was your **torso** positioned during the collision? _____

22. How were your **hands** positioned during the collision? _____

23. Did your **head** hit anything during the collision? Yes No
If yes, please describe. _____

24. Did your **face** hit anything during the collision? Yes No
If yes, please describe. _____

25. Did your **shoulders** hit anything during the collision? _____
If yes, please describe. _____

26. Did your **neck** hit anything during the collision? _____
If yes, please describe. _____

27. Did your **chest** hit anything during the collision? _____
If yes, please describe. _____

28. Did your **hips** hit anything during the collision? _____
If yes, please describe. _____

29. Did your **knees** hit anything during the collision? _____
If yes, please describe. _____

30. Did your **feet** hit anything during the collision? _____
If yes, please describe. _____

31. What kind of headrest was in your vehicle?

Moveable fixed headrest Non-moveable fixed headrest No Headrest

32. Where was the headrest positioned on your head? At the top of the back of your head

at the middle height of the back of your head at the lower portion of the back of your head

at the level of the back of your neck at the level of your shoulder blades

33. Did you have your seat belt on during the collision? Was wearing a shoulder strap seat belt

was wearing a lap belt seat belt was in a baby car seat was in a booster seat

was not wearing a seat belt can not remember if you were wearing a seat belt

34. Did you slide out of your seat belt during the collision? Slid out of your seat belt

partially slid out of your seat belt remained in your seat belt

35. 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 Front left door

Side window Front right door Rear window Back left door Completely totaled

36. Choose the items that dented inward:

Floorboards Side door Dashboard

37. Choose the doors that would not open as a result of the collision:

Front left Rear left Front right Rear right

38. Did you go to the hospital? If no, why and do not answer questions 38 – 43. _____
_____

39. How did you get to the hospital? An ambulance a helicopter a police car

walking drove yourself Other:_____

N/A: Didn't go to the Hospital

40. What was the name of the hospital? _____

41. Were you hospitalized overnight? _____

42. Circle what you were prescribed at the hospital:

Pain medication Muscle relaxers Neck brace

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

44. Did you receive any of the following? Cervical collar Back brace

Cervical collar and back brace Other:_____

45.Were x-rays taken at the hospital? If yes, which area was taken?_____

_____

skull neck mid-back lower-back pelvis hips leg knee foot

shoulder arm No X-rays

46. Was an MRI performed? If yes, which area was taken? _____

_____

47. Did you receive any Special Imaging? If yes, which area was taken?_____

_____

Life was not meant to be a journey to the grave in a pretty & well preserved body but rather to skid in broad sided, thoroughly used up totally worn out & loudly proclaiming

"WOW... What a ride!"