

**CHIROPRACTIC FAMILY HEALTH CENTER OF SEATTLE**  
**AUTO ACCIDENT QUESTIONNAIRE**

**Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Date of Accident:** \_\_\_\_\_

**Brief description of Accident** (i.e. rear-ended, head on, side impact, etc.): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Describe any secondary collisions** (i.e. pushed into vehicle in front of you): \_\_\_\_\_

\_\_\_\_\_

**Do you recall striking anything inside the vehicle?** (i.e. knees on dashboard, head on windshield):

NO YES If yes please describe: \_\_\_\_\_

**What type of vehicle were you in?** \_\_\_\_\_ **Estimated Speed** \_\_\_\_\_

**What type of vehicle was the other driver in ?** \_\_\_\_\_ **Estimated Speed** \_\_\_\_\_

**Describe damage to your vehicle:** Light Moderate Heavy **Damage Estimate** \_\_\_\_\_

**After the accident was your vehicle:** Drivable Not drivable

**Were you:** Driver Passenger

**At the time of the accident visibility was:** Good Poor

**Time of Day:** Daylight Night

**Road conditions** Dry Wet Snow/Ice

**At the time of impact:**

Were you looking? Toward Left Straight ahead Toward Right Up Down

Was your foot on the brake? Yes No

Were you? Braced for Impact Unaware of Impending collision

Were you wearing a seatbelt? Yes No Did your airbag deploy? Yes No

Was you headrest Adjusted properly Not Adjusted Don't Recall