# Auto Accident Questionnaire

Pitt Meadows Wellness.com

Today's Date: ____________

Name: ______________________________ Care Card #: ____________
ICBC Adjustors Name & Phone #: ______________________ Claim #: ____________
Claim Office: ____________ Date of Accident (mm/dd/yyyy): ________ Time: ________(a.m./p.m.)
Have you: Settled your claim with ICBC? __________ Made an Injury Claim with ICBC? __________

## BEFORE & DURING THE IMPACT:

1. Were you the: ❑driver ❑front passenger ❑rear passenger ❑pedestrian *(if so, skip to #8)*
2. Type of accident: ❑rear-end collision ❑side impact (broad-side) ❑head-on collision
   ❑front impact, rear-ended car in front ❑non-collision (describe): ______________________
3. Were you wearing your seatbelt properly? Yes / No
4. Were you wearing a shoulder harness/belt? Yes / No
5. Does your car have: **Headrests?** Yes / No **Airbags?** Yes / No If yes, did it/they inflate? Yes / No
6. What was the position of the headrests compared to your head before the accident?
   ❑top of headrest even with bottom of head ❑top of headrest even with top of head
   ❑top of headrest even with middle of neck ❑unsure
7. Was your car moving at the time of the accident? Yes / No
   If yes, how fast were you going (estimate)?__________ (k.p.h.)
8. How fast was the other car going (estimate)? __________ (k.p.h.)
9. Head / body position at time of impact:
   ❑head turned left / right (circle) ❑body straight in sitting position
   ❑head looking back ❑body rotated left / right (circle)
   ❑head straight forward ❑other: ______________________
10. Describe in your own words what happened to you upon impact: ______________________
    ______________________________________________
11. Did you brace for impact? __________ Yes / No
12. At the time of accident, did any part of your head or body hit anything on the inside of your car? No / Yes
    If yes, describe: ______________________________________________

## PRESENT COMPLAINTS (Reason for your visit today):

______________________________________________
______________________________________________

What activities make your condition / pain worse? ______________________
______________________________________________

What activities make your condition / pain better? ______________________
______________________________________________

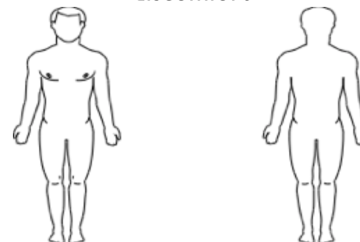
If you have pain, is it… ❑ sharp ❑ dull ❑ radiating ❑ constant ❑ intermittent
❑ mild ❑ moderate ❑ mod-severe ❑ severe

Since it began, is it… ❑ the same ❑ variable ❑ better ❑ worse

What time of day is worst? ❑ waking ❑ at work ❑ evening
❑ at night ❑ variable ❑ constant

Does it interfere with… ❑ work ❑ sleep ❑ walking
❑ sitting ❑ exercise ❑ other

Please mark the area(s) of your discomfort



**OTHER TESTS:** (please circle)
X-rays / CT scan / MRI
Neck / Back / Hips/pelvis

Do you know what the results were? ____________________
____________________
____________________
____________________

***Please turn over***

## PRESENT COMPLAINTS (continued)

Indicate the symptoms you are experiencing as a result of this accident (circle):

- ❑ Dizziness
- ❑ Difficulty sleeping
- ❑ Jaw problems
- ❑ Nausea
- ❑ Memory loss
- ❑ Irritability
- ❑ Arms / shoulder pain
- ❑ Back pain
- ❑ Headache(s)
- ❑ Fatigue
- ❑ Numb hands/fingers
- ❑ Lower back pain
- ❑ Blurred vision
- ❑ Tension
- ❑ Chest pain
- ❑ Back stiffness
- ❑ Buzzing in ear
- ❑ Ears ringing
- ❑ Neck pain
- ❑ Leg pain
- ❑ Stomach upset
- ❑ Shortness of breath
- ❑ Neck stiff
- ❑ Numb feet/toes

Other: ____________________

## POST IMPACT:

Were you transported to hospital? ____________________

Released? __________ Admitted/How long? ____________________

Please describe how you felt:

IMMEDIATELY AFTER the accident: ____________________

LATER THAT DAY: ____________________

THE NEXT DAY: ____________________

What type of injuries did you sustain from the accident?

❑ Bruises ❑ Broken bones ❑ Dislocations ❑ Head injuries ❑ Concussion

Please describe: ____________________

As a result of the accident, you were: ❑ conscious & alert ❑ dazed, circumstances vague ❑ rendered unconscious

❑ other: ____________________

Have you ever had symptoms or received treatments for the area(s) injured in the accident?

Yes / No ____________________ If so, when? ____________________

Were you disabled from the above condition? Yes / No If yes, for how long? ____________________

Do you have any pre-existing conditions that might affect recovery? Yes / No

If yes, describe: ____________________

## WORK ACTIVITIES

Did you go back to work after this injury? Yes / No If Yes, when? ____________________

Are your work activities restricted as a result of this injury? Yes / No If yes, how? ____________________

____________________

How many hours are in your normal workday? ______ What is your job title? ____________________

Please indicate your normal daily job duties/activities (circle):

- ❑ Standing
- ❑ Sitting
- ❑ Driving
- ❑ Work with arms above head
- ❑ Walking
- ❑ Typing
- ❑ Twisting
- ❑ Lifting (weight? ________)
- ❑ Digging
- ❑ Crawling
- ❑ Bending
- ❑ Other: ____________________

While in recovery, is there any light duty work which you could request? Yes / No

Do you work with others who could help you with heavy lifting? Yes / No

Is there anything else you would like us to know? ____________________

I declare these answers to be true to the best of my knowledge.

____________________ Signature

__________ Date

REVISED JULY 24, 2015

***Please turn over***