



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 _____

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 - Sitting: _____

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 your headrest Adjusted properly Not Adjusted Don't Recall

Stop Here. Lower section for doctor's evaluation

MIC1 Subjective symptoms	10pts.
MIC2 Symptoms, Loss of ROM	50pts.
MIC3 Symptoms, ROM & Neuro	90pts.

Modifiers

Canal Size	10-12 mm	20
Canal Size	13-15 mm	15
Kyphotic Cervical Curve		15
Straightened Cervical Curve		10
Blocked/ Fused Segments		15
Loss of Consciousness		15
Pre-existing DJD		10

Hyper/Hypo Mobility on Flex./Ext.

10-30	Excellent
35-70	Good
75-100	Poor
105-125	Guarded
130-165	Unstable

Complicating Health/Lifestyle Factors:
