MOTOR VEHICLE ACCIDENT QUESTIONNAIRE

Please PRINT Legibly

Patient's Name _____ **Today's Date** _____

Referred by _____

Date of Accident:_____ **Time of Accident:**_____ ☐ am ☐ pm

Did this accident occur during the course of your employment or while in a company vehicle? ☐ Yes ☐ No

LOCATION OF THE ACCIDENT: **City**_____ **State** _____

You were traveling ☐ north ☐ south ☐ east ☐ west on _____ (st / ave / hwy)

The other vehicle was traveling ☐ north ☐ south ☐ east ☐ west on _____ (st / ave / hwy)

At the moment of the impact, your vehicle was ☐ stopped ☐ braking ☐ decelerating ☐ accelerating

Your vehicle was traveling at approximating _____mph ☐ unknown

The other vehicle was ☐ braking ☐ stopped ☐ decelerating ☐ accelerating ☐ moving at _____mph ☐ unknown

ROAD CONDITIONS AT THE TIME OF THE ACCIDENT: (check all that apply)

The road surface was ☐ pavement ☐ gravel ☐ dirt ☐ dry ☐ wet ☐ oily ☐ icy ☐ snowy ☐ other _____

Traffic was ☐ light ☐ moderate ☐ heavy _____

VISIBILITY AT THE TIME OF THE ACCIDENT: (check all that apply)

☐ clear ☐ adequate ☐ fair ☐ poor ☐ raining ☐ snowing ☐ fog ☐ other _____

☐ full daylight ☐ dim ☐ dark ☐ lit by street lights ☐ unlit ☐ other _____

VEHICLES INVOLVED:

The vehicle you were in was a _____ (year) Make & Model _____

Who owns the vehicle you were in?_____ Relationship_____

Amount of damage done to that vehicle was ☐ mild ☐ moderate ☐ severe ☐ totaled ☐ unknown $ _____

Was your vehicle drivable? ☐ Yes ☐ No Was it ☐ driven away? Or ☐ towed? By whom? _____

The other vehicle was a _____ (year) Make & Model_____

Amount of damage done to other vehicle was ☐ mild ☐ moderate ☐ severe ☐ totaled ☐ unknown $ _____

The 3rd vehicle was a _____ The 4th vehicle was a _____

YOUR LOCATION INSIDE THE VEHICLE:

You were ☐ the driver ☐ a passenger; ☐ in the front seat ☐ right rear ☐ left rear ☐ a pedestrian

If **you** were driving, were both hands on the wheel? ☐ Yes ☐ No Was your foot on the brake? ☐ Yes ☐ No

If **someone else** was driving, who was the driver?_____

Who else was in your vehicle? _____

YOUR HEAD / BODY POSITION AT THE TIME OF IMPACT:

☐ head was straight forward ☐ body was straight upright in a sitting position

☐ head was turned ☐ left ☐ right ☐ body was rotated ☐ to the left ☐ to the right

☐ you were looking back over your ☐ left ☐ right shoulder? ☐ other _____

Did you see the accident coming? ☐ Yes ☐ No Did you brace for the impact? ☐ Yes ☐ No

Were you using a ☐ lap belt ☐ shoulder strap ☐ both ☐ neither Did it engage? ☐ Yes ☐ No

Was there an airbag at your position? ☐ Yes ☐ No Did it deploy? ☐ Yes ☐ No

Were you injured by the safety equipment? ☐ Yes ☐ No If yes, what was the injury? _____

Was a headrest available at your position? ☐ Yes ☐ No ☐ unknown

If "yes", what was the position of your headrest compared to your head before the accident?

The top of the headrest was even with the ☐ top ☐ middle ☐ bottom of your head ☐ unknown

The back of your head was _____ inches in front of the headrest

TYPE OF COLLISION: (number all that apply in a 1-4 sequence if more than one impact occurred to your vehicle)

☐ head-on collision ☐ you were rear-ended ☐ you rear-ended the vehicle in front of you

☐ they hit your side ☐ you hit their side ☐ side-swipe ☐ non-collision ☐ single car versus object _____

As a result of the impact, was your vehicle (1) propelled forward ☐ Yes ☐ No or (2) its path re-directed ☐ Yes ☐ No

Did any police arrive at the scene? ☐ Yes ☐ No Were any traffic citations issued? ☐ Yes ☐ No

To whom?_____ For what infraction? _____

Describe how the accident occurred _____

_____

_____

PLEASE DIAGRAM BELOW HOW THE ACCIDENT HAPPENED: Label each vehicle **A** **B** **C, D,** etc.

Describe in your own words **what happened to <u>your body</u>** (not the vehicles) upon impact: _____

_____

_____

At the time of the accident, what parts of your body hit what parts of the inside of your vehicle?

Explain _____

Did you get any bruises, abrasions or bleeding cuts? ☐ Yes ☐ No

If "yes", describe _____

Did you feel or hear any tearing, popping or ripping noise in your neck or back? ☐ Yes ☐ No

Did you feel any pain **at the moment of impact**? ☐ Yes ☐ No What? _____

If no immediate pain, how long until you felt any symptoms? _____

What symptoms _____

As a result of the accident, you were:

☐ Dazed, confused, circumstances vague ☐ Rendered unconscious ☐ No ☐ Yes for how long?_____

☐ Shaken up but could think clearly and function ☐ other _____

FOLLOWING THE ACCIDENT, was your body in the same location inside the car as before the accident?

☐ Yes ☐ No If "no", explain _____

Could you move all parts of your body? ☐ Yes ☐ No

If "no", what parts and why? _____

Were you able to get out of the vehicle and walk unaided? ☐ Yes ☐ No

If "no", why not? _____

Did any emergency vehicles arrive at the scene? ☐ Yes ☐ No

Did you receive any medical assistance at the scene of the accident? ☐ Yes ☐ No What? _____

When did you first feel the symptoms you have now? _____

Please describe your symptoms:

Immediately **after** the accident _____

Later that day / night _____

The next day, etc. _____

Where did you go after the accident? ☐ Home ☐ other_____ How did you get there? _____
Were you taken to a hospital ☐ Yes ☐ No Name & Location _____
How did you get there? ☐ drove own car ☐ someone else drove me ☐ ambulance ☐ police ☐ other _____
Who attended you?_____
Tests done: ☐ physical exam ☐ x-rays ☐ CT/MRI ☐ blood ☐ urine Diagnosis _____
What treatments / medications were given / prescribed? _____
What recommendations were made?_____
Were you hospitalized as a result of this accident? ☐ Yes ☐ No For how long? _____
Has surgery been performed? ☐ Yes ☐ No _____ Has surgery been recommended? ☐ Yes ☐ No
Have you seen any other doctors for this accident? ☐ Yes ☐ No Who & when? _____
_____

Are you currently under care or taking medication for this injury? ☐ Yes ☐ No
Present doctor's name & address_____
How often do you see this doctor?_____ Over what period of time? _____
What benefits have you received from this treatment?_____
What home care did you try? ☐ rest ☐ exercise ☐ ice ☐ heat ☐ aspirin ☐ ibuprofen _____

PLEASE PLACE AN "**X**" AT ALL SYMPTOMS YOU HAVE NOTICED **SINCE** THE ACCIDENT.
Additionally, **underline** any symptoms that you had **just prior** to the accident.

☐ headaches	☐ light-headedness	☐ ringing in ears	☐ lights bother eyes
☐ pain behind eyes	☐ dizziness	☐ buzzing in ears	☐ visual disturbance
☐ jaw pain ☐ jaw tension	☐ head seems heavy	☐ hearing loss	☐ difficulty swallowing
☐ neck pain	☐ pins & needles in arms	☐ loss of balance	☐ upset stomach
☐ neck stiffness	☐ pins & needles in legs	☐ fatigue	☐ diarrhea
☐ restricted neck motion	☐ numbness in fingers	☐ fainting	☐ constipation
☐ upper back pain	☐ numbness in toes	☐ face flushed	☐ anxious feelings
☐ mid back pain	☐ cold hands	☐ loss of smell	☐ irritability
☐ low back pain	☐ cold feet	☐ loss of taste	☐ nervousness
☐ low back stiffness	☐ difficulty concentrating	☐ cold sweats	☐ tension
☐ rapid heart beat	☐ poor memory	☐ decreased sexual function	☐ problems sleeping
☐ chest pain	☐ mental dullness	☐ decreased sexual interest	☐ periods of depression
☐ shortness of breath	☐ muscle weakness	☐ loss of feeling (where?)_____	
☐ excessive sweating	Symptoms other than above_____		

SINCE THE INJURY, are your symptoms:
☐ the same ☐ improving ☐ no longer improving ☐ getting worse ☐ constant ☐ worse at times
Is it painful to move your **head**: ☐ right ☐ left ☐ forward ☐ backward ☐ when rising from a lying position
Is it painful to bend your **trunk**: ☐ right ☐ left ☐ forward ☐ backward ☐ turning to the ☐ left ☐ right
What positions, movements or activities cause discomfort _____
What positions are comfortable: ☐ sitting ☐ standing; lying on your ☐ back ☐ right side ☐ left side ☐ stomach
Do any of the following give any relief: ☐ ice pack ☐ heating pad ☐ hot bath/shower ☐ stretching ☐ brace/collar

PRIOR / SIMILAR COMPLAINTS:
Have you **ever** had any complaints in the involved area(s) before? ☐ Yes ☐ No
If "yes", when_____ What were the complaints?_____
Was there an injury involved? ☐ Yes ☐ No What occurred?_____
What treatment was given _____ Was recovery complete? ☐ Yes ☐ No
What prior problems still existed at the time of this accident?_____
Since this injury, have there been any additional traumas, accidents, aggravations, etc? _____

WORK / ACTIVITY STATUS:

Your occupation_____ Job duties_____
Your employer_____ Who to contact at your work_____
Address_____ Phone_____ ext_____

Before the injury, were you capable of working on an equal basis with others your age? ☐ Yes ☐ No
Are your **current work activities** restricted as a result of this injury? ☐ Yes ☐ No
What restrictions?_____
Are you currently **able** to work? ☐ Yes ☐ No **Are** you working? ☐ Yes ☐ No ☐ Full Time ☐ Part Time_____

Have you lost any time from work as a result of this accident: ☐ Yes ☐ No If, "yes", how many days?_____
Last day you worked at full capacity _____ Last day you worked at all_____
Totally disabled from_____ to_____
Partially disabled from_____ to_____
Light Duty from_____ to_____
Part Time from_____ to_____
Are you being or have you been compensated for the time lost from work? ☐ Yes ☐ No
What type of compensation? _____

Are there any non-occupational activities that you usually perform that you find you cannot do now without pain or difficulty? (Daily routine, around the house, recreation, etc.) Please describe _____

_____

_____

Have you contacted a lawyer regarding this accident? ☐ Yes ☐ No
Name_____ Phone Number_____

FEMALES ONLY: Do you have breast implants? ☐ Yes ☐ No
Were you pregnant at the time of the accident? ☐ Yes ☐ No How many weeks / months? _____
Date your last menstrual cycle began_____ Is there **any** chance that you may now be pregnant? ☐ Yes ☐ No

OTHER PERTINENT INFORMATION

_____

_____

_____

_____

_____

_____

_____

_____

Patient's / Guardian's Signature_____ **Date**_____