Motor Vehicle Collision Questionnaire

Please answer all questions completely:

1. Your name and address:

_____

_____

_____

2. Phone number: _____

3. Please describe the collision in your own words:

_____

_____

_____

4. Where did the collision occur? City/Town: _____State____

5. Date of collision: _____Time_____AM/PM

6. Were you the: ___driver ___passenger ___pedestrian

7. If passenger, were you in the: __front seat __right rear seat __left rear seat

8. What type of vehicle were you in? _____

9. What type was the other vehicle? _____

10. Did your vehicle strike the other vehicle? ___Yes ___No

11. Was your car struck by the other vehicle? ___Yes ___No

12. What direction was your vehicle going? _____

13. What direction was the other vehicle going? _____

14. Was the impact from: __the front __the rear __the left side __the right side

15. What was the approximate speed at the time of impact?

Your vehicle _____mph Other vehicle _____mph

16. What was the weather at the time of the collision? ___dry ___wet ___icy

17. Was your vehicle in:___park ___neutral ___in gear ___moving ___stopped

18. Were your brakes being applied? ___Yes ___No

19. Was your vehicle shoved: ___forward ___backward ___sideways

20. Were you shoved: ___forward ___backward ___sideways

21. Did your seat have a head restraint (headrest?) ___Yes ___No

22. If yes, what was the position? ___low ___mid-position ___high
23. Did your head ride over the headrest? ___Yes ___No
24. Did your hat/glasses end up in the back seat or rear window? ___Yes ___No
25. Did any other part of your body hit the interior of the vehicle? ___Yes ___No
26. If yes, please specify: ___ seatbelt ___steering wheel ___dashboard
    ___windshield ___side door ___side window ___other:_____
27. Which part of your body? ___chest ___head ___chin ___face ___R L knee
    ___R L shoulder ___R L hand ___other: _____
28. Were you holding on to the steering wheel? ___Yes ___No
29. Did you brace your arms against the dash? ___Yes ___No
30. Did you brace your legs against the floorboard? ___Yes ___No
31. Was your ankle turned? ___Yes ___No
32. Did the vehicle go into a spin or roll as a result of the impact? ___Yes ___No
33. If yes, explain: _____
34. How much damage was there to the outside of the vehicle?
    ___none ___some ___a lot
35. How much damage was there to the outside of the vehicle?
    ___none ___some ___a lot
36. At the point of impact, where did you experience pain? Please be specific:
    _____
    _____
    _____
37. Immediately after the accident were you: __conscious __dazed
    __unconscious
38. If you lost consciousness, how long? _____
39. Were you wearing a seat belt? ___Yes ___No
40. Did the belt have a shoulder harness? ___Yes ___No
41. If yes, did it contribute to the pain you are experiencing? ___Yes ___No
42. At the time of impact, were you: __looking straight ahead
    __looking to the right __looking to the left __looking down ___looking up
43. Did the seat break as a result of the impact? ___Yes ___No

44. Were you braced for the impact? ___Yes ___No

45. Were you surprised by the impact? ___Yes ___No

46. Did you go to the hospital? ___Yes ___No

47. If yes, when? ___right after the accident ___next day ___other: _____

48. If yes, how did you get there? ___ambulance ___other: _____

49. If by ambulance, did the ambulance attendants place you in a: __neck brace __back brace __other: _____

50. Any medication or medical supplies given? _____

51. Did you have x-rays taken at the hospital? ___Yes ___No

If you went to the hospital, please answer the following:

Name of hospital_____

Name of doctor_____

Diagnosis_____

Treatment Received_____

52. Have you had any similar problems before? ___Yes ___No

53. If yes, explain: _____

54. Are you diabetic? ___Yes ___No

55. Do you have high blood pressure? ___Yes ___No

56. Do you have low blood pressure? ___Yes ___No

57. Do you have arthritis or degenerative joint disease? ___Yes ___No

58. What type of work do you do? _____

59. What are your job requirements? _____

60. Have you lost any days of work from this injury? ___Yes ___No

61. If yes, give dates:_____

Patient Signature_____ Date_____

Printed name_____

Witness Signature_____ Date_____