Motor Vehicle Collison QUESTIONNAIRE

PLEASE ANSWER ALL QUESTIONS COMPLETELY

Today's date____/____/____

Your present injury occurred at (approx.) ____:____ AM PM on the date ____/____/______

Patient name____ Tele#____________________________

Sex M F Marital Status Date of Birth_____________ Home Phone_____________________________

Who may we thank for referring you to our office? ____

Social Sec # (last 4)_____________ Your Company Name ____

Business Phone ____________________Company Address____

Other Vehicle

Driver of other vehicle (if any) ____ Driver DOB____/____/____

Was driver wearing logo/uniform or was driver in a commercial vehicle? Yes No _________________________

Other car auto insurance company___________________________ Address_________________________________

Phone#____________________ Policy No.________________________ Claim No.___________________________

Claim Rep__________________________________ Phone & Ext_______________________________________

Your Vehicle Insurance

Name of driver of vehicle in which you were injured (self or other) ____

Owner of vehicle (self or other) ____DOB____/____/_____

Make, model, year of vehicle: ____

Estimate of damages: (if avail include documentation):____

Your auto insurance company_____________________________ Address___________________________________

Phone#:____________________ Policy No.________________________ Claim No.____________________________

Insurance representative____ Phone/Ext_____________________

Have you retained an attorney? Yes No Not Yet Would you like more information on this?

If so, name, address & phone#____

Incident Information

(Name of roadway)

Patient was heading? North South East West on____

Please explain in detail how your collision happened? ____

____

Number of people in your vehicle__________________

Passengers (full names) ____

» Were police notified? Yes No » Did police arrive? Yes No » Do you have a police report? Yes No

» Which agency? ____________________________ City/County/State____________________________________

Motor Vehicle Collison QUESTIONNAIRE

PLEASE ANSWER ALL QUESTIONS COMPLETELY

Injuries/Treatment

Did you feel pain immediately after the collision? Yes No Later that day Next day When?__________

Where did you feel pain immediately after the collision? ____

Where were you taken after the collision? EMS not dispatched Refused ER Urgent Care Other ________

Was treatment given? ____

Was any doctor consulted after the collision? Yes No If Yes: GP/PCP ER Urgent Care Other

If so, give doctor's name_____________________________________ D.C., M.D., D.O., D.D.S.

Doctor's diagnosis____

Was treatment/medication was given? Yes No *If yes:* ____

How often did you see the doctor? 1x 2x 3x more ___________

Have you missed time from work as a result of the collision? Yes No if Yes how many days?________________

Have you ever had any complaints in the involved/injured area before? Yes No

If so, what were the complaints? ____

Before the injury, were you capable of working on an equal basis with others your age? Yes No

Are your work activities restricted as a result of this collision? Yes No

Since the injury, are your symptoms Improving? Getting worse? The same?

Impact Statement

1. Patient was Driver Passenger Pedestrian Bicyclist Motorcyclist
2. From which angle were they struck? Behind Front Left Right
3. Did the airbag deploy? Yes No *If Yes,* was it the: Steering Wheel Side Curtain Other ________
4. What was the patient doing at the time of the impact? Driving Passenger Walking Standing Running
5. Was patient moving at the time of impact? Full stop Fast Slow Approx Speed _________
6. What was the other involved person doing at the time of impact? Full stop Moving Approx Speed ________
7. Was the patient wearing a seat belt? Yes No
8. Did seatbelt operate as intended? Yes No If No, explain: ______________________________________
9. Which direction was patient's head turned at impact? Foreword to Right to Left Behind Up Down
10. Was the patient alone or with others during the time of impact? Single occupant Passengers #_______
11. Did any of the patient's body hit another structure at the time of impact? (Ex: left arm) Yes No
    If yes:____
12. Did any part of the vehicle did patient's body hit? (Ex: steering wheel) Yes No
    If yes: _______________________________________
13. How did the patient feel immediately after collision? Stunned Intense Pain Discomfort Frightened
    Popping & Ripping Lost Consciousness *If so, for how long Hrs_____: Mins_____* other________________

Patient Name (print): ____ **Staff Initials:** ________

Patient signature: ____

@PM, Inc., 1996 Form 08/C (edited by WFC May2019)