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_____ Marital Status_____ Date of Birth_____ Home Phone_____

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

Social Sec. #_____ 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._____

Name of person who has made contact with you_____

Your Vehicle

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_____ Ext/Direct#_____

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

If so, name, address & phone #_____

Incident Information

You were heading? □ North □ South □ East □ West on_____ (street or highway)

Please explain in detail how your collision happened? _____

_____

Number of people in your vehicle_____

Passengers (full names) _____

Were police notified? □ No □ Yes Which agency _____City/County _____

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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 so, give doctor's name_____□ D.C., □ M.D., □ D.O., □ D.D.S.

Doctor's diagnosis_____

What treatment was given? _____

How often did you see the doctor? _____

How long did you see the doctor? _____

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 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? If yes was it the: □ Steering Wheel □ Side Curtain □Both
4. What was the patient doing at the time of the impact? □ Stopped □ Moving □ Walking □ Standing Still □Running
5. At what speed was the patient moving at the time of impact? □Moving □Approx Speed _____
6. What was the other involved person doing at the time of impact? □Moving □Approx Speed _____
7. What was the other involved person's speed? □Moving □Approx Speed_____
8. Was the patient wearing a seat belt? □Yes □No Did it operate as intended? □Yes □No _____
9. Was the patient's head turned at the time of impact? □Foreword □to Right □to Left □Behind □Up □Down
10. Was the patient alone or with others during the time of impact? □No _____# of passengers
11. What part of the patient's body hit another structure at the time of impact? Ex: left arm
    _____
12. What structures did the patient's body hit? Ex: steering wheel _____
13. How did the patient felt immediately after the collision? □Stunned □Intense Pain □Discomfort □Frightened □Popping & Ripping □Lost Consciousness *If so, for how long Hrs_____: Mins_____*

Patient Name: _____ **Patient File #:** _____

Duties Performed Under Duress at Work and Home

Date _____ Date of Injury _____

☐ Initial ☐ Update ☐ Final

Please check all that apply to your WORK because of the accident

☐ I go to work but work in pain
☐ I limit my work activities
☐ Bending at work hurts
☐ Stooping at work hurts
☐ Sitting at work hurts
☐ Using the Computer at work hurts
☐ Pushing at work hurts
☐ Pulling at work hurts
☐ Kneeling at work hurts
☐ I have lost status in my company
☐ I have lost job security
☐ I didn't get a promotion
☐ I don't enjoy work as much as before
☐ I doze off at work
☐ I take unpaid time off work to go to Dr.
☐ I daydream at work more than before
☐ I feel tired at work
☐ _____
☐ _____

☐ I work in pain because I have bills to pay
☐ I can't take time off because I would lose my job
☐ I keep working so I don't lose stat us at company
☐ My business would fail if I took time off
☐ I believe in working even when I'm in pain
☐ I feel obligated to work even though I'm in pain
☐ My business would lose money if I took time off
☐ My work is not as good as it was before accident
☐ My boss reprimanded me for poor performance
☐ I got a different job within the same company
☐ I got a different job in another company
☐ I make less money than before the accident
☐ I cannot do the same work/job as before accident
☐ I can't concentrate as well at work
☐ I take paid time off to go to Dr.
☐ I make mistakes at work I didn't used to
☐ I hide my poor work performance from my boss
☐ _____
☐ _____

☐ My house is not as clean now
☐ My yard is not as neat now
☐ My garden is not as productive now
☐ I do yard work, but do it in pain
☐ I cannot do my normal yard work
☐ I do house work, but do it in pain
☐ I cannot do my normal house work
☐ Doing laundry hurts me
☐ I cannot do laundry now
☐ Washing dishes hurts me
☐ I cannot wash dishes now
☐ Vacuuming hurts me
☐ I cannot vacuum now
☐ Cooking hurts me
☐ I cannot cook now
☐ Washing the car hurts me
☐ I cannot wash my car
☐ _____
☐ _____

☐ I cannot take time off because I care for children
☐ I have _____ children ages _____
☐ I had to hire a paid housekeeper
☐ I asked someone for unpaid housekeeping help
☐ I had to hire a paid gardener
☐ I asked someone for unpaid yard work help
☐ Mowing the lawn hurts me
☐ I cannot mow the lawn
☐ Taking out the trash hurts me
☐ I cannot take out the trash
☐ I do not enjoy my gardening/yardwork like I used to
☐ I do not enjoy my housework like I used to
☐ Gardening hurts me
☐ I cannot do my gardening at all since the accident
☐ Others living with me do my share of the work now
☐ Others living with me do my share of the yard work
☐ Others living with me do my share of the gardening
☐ _____
☐ _____

Signature _____ Date _____

Patient Name: _____ **Patient File #:** _____

Loss of Enjoyment of Sports, Hobbies, Travel, Daily Activities, & School

Date _____ Date of Injury _____

☐Initial ☐Update ☐ Final

Please check all that apply to your EXERCISE & SPORTS Activity *because of the accident*

☐ My exercise was affected by this crash
☐ I go to the gym & work out in pain
☐ I no longer go to the gym to work out
☐ I run but in pain
☐ I no longer run
☐ I take walks & have pain while walking
☐ I no longer take walks
☐ I used to make income at sports
☐ I have lost sports income since crash
☐ I am an amateur athlete
☐ I am a professional athlete
☐ _____
☐ _____

☐ I have gained _____ pounds since the accident
☐ I had to quit my _____ team after the accident
☐ I had to quit my _____ team after the accident
☐ I had to quit my _____ team after the accident
☐ I had to quit my _____ team after the accident
☐ I don't enjoy the sport of _____ __ anymore
☐ I didn't enjoy the sport of _____ for ____ weeks
☐ I don't enjoy the sport of _____ anymore
☐ I didn't enjoy the sport of _____ for ____ weeks
☐ I don't enjoy the sport of _____ anymore
☐ I didn't enjoy the sport of _____ for ____ weeks
☐ I don't enjoy the sport of _____ anymore
☐ I didn't enjoy the sport of _____ for ____ weeks

Please check all that apply to your HOBBY Activities *because of the accident*

☐ My hobbies were affected by accident
☐ Hobby #1 _____
☐ I can't do hobby #1 anymore
☐ I do hobby #1 but in pain
☐ I have lost money from not doing #1
☐ I didn't do hobby #1 for _____ weeks
☐ Hobby #2 _____
☐ I can't do hobby #2 anymore
☐ I do hobby #2 but in pain
☐ I have lost money from not doing #2
☐ I didn't do hobby #2 for _____ weeks

☐ Hobby #3 _____
☐ I can't do hobby #3 anymore
☐ I do hobby #3 but in pain
☐ I have lost money from not doing #3
☐ I didn't do hobby #3 for _____ weeks
☐ Hobby #4 _____
☐ I can't do hobby #4 anymore
☐ I do hobby #4 but in pain
☐ I have lost money from not doing #4
☐ I didn't do hobby #4 for _____ weeks
☐ _____

Please check all that apply to your TRAVEL Activities *because of the accident*

☐ Business travel was affected by crash
☐ Pleasure travel was affected by crash
☐ I hurt driving in my own car
☐ I am in too much pain to drive
☐ I hurt when a passenger in a car
☐ I am in too much pain to sit in a car
☐ I have anxiety when I'm in a car
☐ I hurt when I'm on an airplane
☐ I am in too much pain to travel by plane

☐ Travel Plan #1 _____
☐ I did not go on travel plan #1
☐ I went, but did not enjoy #1 as much
☐ I went and the accident had no effect on #1
☐ Travel Plan #2 _____
☐ I did not go on travel plan #2
☐ I went, but did not enjoy #2 as much
☐ I went and the accident had no effect on #2
☐ I missed time with my family/friends b/c can't travel

Patient Name: _____ **Patient File #:** _____

Loss of Enjoyment of Sports, Hobbies, Travel, Daily Living, & School (p. 2 of 2)

Date _____ Date of Injury _____

☐ Initial ☐ Update ☐ Final

Please check all the DAILY LIVING Activities that cause you pain *because of the accident*

☐ Dressing
☐ Putting on pants
☐ Putting on shoes
☐ Tying my shoes
☐ Putting on shirt
☐ Combing my hair
☐ Drying my hair
☐ Washing my hair
☐ Taking a shower
☐ Taking a bath
☐ Leaning Forward
☐ Laying in bed
☐ Sitting in my favorite chair
☐ Sleeping
☐ Going out with my friends
☐ Sitting in a restaurant
☐ Shopping
☐ Driving to/from work
☐ Sitting in Church
☐ Playing with my children
☐ Caring for my children
☐ Bending at the waist
☐ Sitting in a movie theater
☐ Exercise
☐ Eating
☐ Stooping
☐ Squatting
☐ Kneeling
☐ Brushing my teeth
☐ Riding in a car
☐ Opening a jar
☐ Lifting a pan when cooking
☐ Closing the trunk on my car
☐ Opening the garage door
☐ Using my home computer
☐ Climbing stairs
☐ Going down stairs
☐ Sexual activity
☐ Turning my head to left or right
☐ Holding my head up all day
☐ Watching TV
☐ I have pain sitting & doing nothing
☐ Talking on the phone
☐ Reading
☐ Writing
☐ Opening doors
☐ Drying with a towel after a bath or shower
☐ Life has become a chore just to do normal things
☐ It is depressing to live like this
☐ _____
☐ _____
☐ _____
☐ _____
☐ _____
☐ _____
☐ _____
☐ _____
☐ _____

Please check all that apply to your SCHOOL & EDUCATION Activities *because of the accident*

☐ School was affected by the accident
☐ I am a student at _____
☐ I am in the _____ year/grade
☐ I was ☐ full time ☐ part time
☐ I am now ☐ full time ☐ part time
☐ I had to take fewer classes b/c of crash
☐ I missed _____ days of school
☐ I had to drop out of school b/c of crash
☐ My grades are lower since the crash
☐ I have pain carrying my school books
☐ I hurt sitting in class more than _____ minutes
☐ My neck hurts when I look down to read
☐ I don't learn as quickly as before the crash
☐ I don't learn thing s as well as before the crash
☐ I have difficulty concentrating in class
☐ It takes much longer to study/do my homework
☐ _____
☐ _____

Signature of Patient _____ Date _____

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Have You Opened a Medical Claim?

If you are in an auto accident and experiencing related symptoms then you must open a medical claim with YOUR insurance company. In Texas (and many other states) medical claims are paid under PIP (Personal Injury Protection). In other states medical claims are paid under MedPay. Both coverage types typically come with your insurance policy. In Texas it is a state law that PIP be on your policy. It can only be removed in writing by the primary policy holder and there must be a "Waiver of PIP" in your insurance file.

PIP and MedPay allow you to seek medical attention, pay for ambulance transport and/or emergency room care. In either case, your own auto policy typically isn't affected at all by a medical claim. It is insurance that you have already paid for.

It is improper for practitioners to file to your health insurance for medical treatment as the result of a motor vehicle accident (MVA). If fault of the accident is proven to be someone other than yourself YOUR insurance company may re-coup paid medical bills from the at-fault driver's insurance company.

So that we may have all the information we need in order to file billing for your treatment please contact your insurance company immediately and notify them that you were in an accident and need to seek medical treatment. They will open a medical claim and you will be given a medical adjuster and claim number. Please share with us this information so we may better serve you.

In the event there isn't PIP or MedPay or you still choose to not open a medical claim there is the option to wait for payment from the 3rd party (the responsible driver's insurance) to reimburse you. In this case, you will cover the expenses for your medical treatment and wait until a settlement occurs, which can take up to a year. If you secure an attorney, then they work on your behalf to settle the case and the medical bills. We are happy to recommend one of the attorney's we have worked well with, if you would like referral. If you are trying to work to get the 3rd party to reimburse, they will want and evaluate all medical records. The level of record keeping required by us is substantial and we are obligated to bill for each and every service we provide, just as we would for any health insurance.

You may find it beneficial to talk to an attorney. Attorneys only take a percentage of the total settlement, they do not charge upfront. They can give you a snapshot of what the case is potentially worth in dollar value.

Please let us know as soon as possible how you will proceed so we can help you understand any charges or payments that may be required.

Your insurance company:	
Your policy number:	
Your medical claim adjuster:	
Your medical claim number:	
Your accident claim number (if applicable):	
The at-fault driver insurance company:	
The at-fault driver policy number:	
The at-fault driver adjuster:	
The at-fault driver claim number:	