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 good 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 seat 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

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

top of headrest even with bottom of your head top of headrest even with top of your head

top of headrest even with middle of your head unknown

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: ____________________

____

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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 Yes No (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. ____

Name___________________________________ **Page 3** **Today's Date** _____________

Where did you go after the accident? Home Work 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 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? _________________________

Have you seen any other doctors for this accident? Yes No Who & when? _________________________

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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?____

Has surgery been performed? Yes No ________________ Has surgery been recommended? Yes No

What home care did you try? rest exercise ice heat aspirin ibuprofen, etc.__________________

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

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?_______________________

Name___________________________________ **Page 4** **Today's Date** _____________

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

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Patient's / Guardian's Signature____ **Date**_________________