MOTOR VEHICLE COLLISION QUESTIONNAIRE

Name_____ **Todays Date** _____
Last **First** **Middle**

ACCIDENT INFORMATION

Date of accident_____ **Time of accident**_____ ☐ a.m. ☐ p.m. **Was the accident work related?** ☐ Yes ☐ No

Were you the: ☐ Driver ☐ Front Passenger ☐ Rear Passenger ☐ Other _____ **Number of people in the accident vehicle?**____

Type of collision: ☐ head on ☐ rear end ☐ broad side ☐ front impact, rear ended car in front ☐ Other _____

Did the impact to your vehicle come from the: ☐ Front ☐ Rear ☐ Right Side ☐ Left Side ☐ Other _____

What did your vehicle impact? ☐ Another vehicle ☐ Nothing ☐ Other _____

Did the police come to the accident site? ☐ Yes ☐ No **Was a police report filed?** ☐ Yes ☐ No

Was a citation/ticket issued? ☐ Yes ☐ No **If yes, to whom and for what was it issued?** _____

Were you wearing a shoulder harness? ☐ Yes ☐ No **Were you wearing a lap belt?** ☐ Yes ☐ No

Was the vehicle equipped with air bags? ☐ Yes ☐ No **If yes, did they inflate?** ☐ Yes ☐ No

Did any part of your body strike anything in the vehicle? ☐ Yes ☐ No **If yes, please describe:** _____

_____

In relation to your skull, where was the headrest? ☐ Above ☐ Below ☐ At base of skull ☐ Other _____

During the impact, were you facing: ☐ Forward ☐ Right ☐ Left ☐ Other _____

Were you aware of the upcoming impact? ☐ Yes ☐ No **Were you braced for the upcoming impact?** ☐ Yes ☐ No

Was your foot on the brake at impact? ☐ Yes ☐ No **Was your foot on the clutch at impact?** ☐ Yes ☐ No

Make, model and year of the vehicle you were occupying: _____

Make, model and year of the other vehicle(s) involved in the accident: _____

What was the approximate speed of your vehicle? _____mph **Approximate speed of the other vehicle?** _____mph

In your own words, please describe the accident in detail: _____

_____

_____

AFTER THE ACCIDENT

Did the accident render you unconscious? ☐ Yes ☐ No **If yes, for how long?** _____ **Please describe how you felt immediately following the accident:** _____

Have you gone to another Hospital/Doctor? ☐ Yes ☐ No **Name of Hospital/Doctor:** _____

When did you go? ☐ Just after the accident ☐ The next day ☐ 2 days plus **How did you get there?** ☐ Ambulance ☐ Private Auto.

Were x-rays taken? Yes ☐ No **If yes, please describe:** _____

Was medication prescribed? ☐ Yes ☐ No **If yes, what:** _____

Describe any treatment you received: _____

Have you been able to work since the accident? ☐ Yes ☐ No **Have you been working part time?** ☐ Yes ☐ No

Please describe any work limitations/restrictions: _____

SYMPTOMS

Indicate symptoms that are a result of this accident: ☐ Dizziness ☐ Headaches ☐ Blurred vision ☐ Ears ringing ☐ Tension
☐ Neck pain ☐ Neck stiff ☐ Jaw problems ☐ Arms/Shoulder pain ☐ Numb Hands/Fingers ☐ Chest pain ☐ Nausea ☐ Memory loss
☐ Back pain ☐ Lower back pain ☐ Back stiffness ☐ Leg pain ☐ Numb Feet/Toes ☐ Stomach upset ☐ Buzzing in ear ☐ Fatigue
☐ Irritability ☐ Other _____ **Is your condition getting worse?** ☐ Yes ☐ No ☐ Constant ☐ Comes and goes