

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

Name _____

Page 2

Today's Date _____

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   C, D, etc.

Describe in your own words **what happened to your body** (not the vehicles) upon impact: _____

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? _____

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.

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> headaches | <input type="checkbox"/> light-headedness | <input type="checkbox"/> ringing in ears | <input type="checkbox"/> cold hands |
| <input type="checkbox"/> pain behind eyes | <input type="checkbox"/> dizziness | <input type="checkbox"/> buzzing in ears | <input type="checkbox"/> cold feet |
| <input type="checkbox"/> neck pain | <input type="checkbox"/> head seems heavy | <input type="checkbox"/> hearing loss | <input type="checkbox"/> difficulty swallowing |
| <input type="checkbox"/> neck stiffness | <input type="checkbox"/> pins & needles in arms | <input type="checkbox"/> loss of balance | <input type="checkbox"/> upset stomach |
| <input type="checkbox"/> restricted neck motion | <input type="checkbox"/> pins & needles in legs | <input type="checkbox"/> fatigue | <input type="checkbox"/> diarrhea |
| <input type="checkbox"/> upper back pain | <input type="checkbox"/> numbness in fingers | <input type="checkbox"/> fainting | <input type="checkbox"/> constipation |
| <input type="checkbox"/> mid back pain | <input type="checkbox"/> numbness in toes | <input type="checkbox"/> face flushed | <input type="checkbox"/> irritability |
| <input type="checkbox"/> low back pain | <input type="checkbox"/> lights bother eyes | <input type="checkbox"/> loss of smell | <input type="checkbox"/> nervousness |
| <input type="checkbox"/> low back stiffness | <input type="checkbox"/> difficulty concentrating | <input type="checkbox"/> loss of taste | <input type="checkbox"/> tension |
| <input type="checkbox"/> rapid heart beat | <input type="checkbox"/> anxious feelings | <input type="checkbox"/> cold sweats | <input type="checkbox"/> visual disturbance |
| <input type="checkbox"/> chest pain | <input type="checkbox"/> poor memory | <input type="checkbox"/> decreased sexual function | <input type="checkbox"/> mental dullness |
| <input type="checkbox"/> shortness of breath | <input type="checkbox"/> sleeping problems | <input type="checkbox"/> decreased sexual interest | <input type="checkbox"/> periods of depression |
| <input type="checkbox"/> excessive sweating | <input type="checkbox"/> muscle weakness | <input type="checkbox"/> 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

Patient's / Guardian's Signature _____

Date _____