**MOTOR VEHICLE COLLISION QUESTIONNAIRE**

**Please answer all questions completely:**

1: Your name and address:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2: Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3: Please describe the collision in your own words:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4: Where did the collision occur? City/Town: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_

5: Date of collision: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ AM PM

6: Were you the: 􀂆 driver 􀂆 passenger 􀂆 pedestrian

7: If passenger, were you in the 􀂆 front seat 􀂆 right rear seat 􀂆 left rear seat

8: What type of vehicle were you in? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

9: What type was the other vehicle? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

10: Did your vehicle strike the other vehicle? 􀂆 yes 􀂆 no

11: Was your car struck by the other vehicle? 􀂆 yes 􀂆 no

12: What direction was your vehicle going? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

13: What direction was the other vehicle going? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

14: Was the impact from: 􀂆 the front 􀂆 the rear 􀂆 the left side 􀂆 the right side

15: What was the approximate speed at the time of the impact?

16: Your vehicle \_\_\_\_\_\_\_\_\_ mph Other vehicle \_\_\_\_\_\_\_\_\_\_ mph

17: What was the weather at the time of the collision? 􀂆 dry 􀂆 wet 􀂆 icy

18: Was your vehicle in: 􀂆 park 􀂆 neutral 􀂆 in gear 􀂆moving 􀂆stopped

19: Were your brakes being applied? 􀂆 yes 􀂆 no

20: Was your vehicle shoved: 􀂆 forward 􀂆 backward 􀂆 sideways

21: Were you shoved: 􀂆 forward 􀂆 whipped backward

22: Did your seat have a head restraint (headrest?) 􀂆 yes 􀂆 no

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

23: If yes, what was the position 􀂆 low 􀂆 mid-position 􀂆 high

24: Did your head ride over the headrest? 􀂆 yes 􀂆no

25: Did your hat/glasses end up in the back seat or rear window? 􀂆 yes 􀂆 no

26: Did any other part of your body hit the interior of the vehicle? 􀂆 yes 􀂆 no

27: If yes, please specify: 􀂆 seatbelt restraints 􀂆 steering wheel 􀂆 dashboard

􀂆 windshield 􀂆 side door 􀂆 side window 􀂆 other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

28: Which part of your body? 􀂆 chest 􀂆 head 􀂆 chin 􀂆 face 􀂆 R L knee

􀂆 R L shoulder 􀂆 R L hand 􀂆 other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

29: Were you holding on to the steering wheel? 􀂆 yes 􀂆 no

30: Did you brace your arms against the dash? 􀂆 yes 􀂆 no

31: Did you brace your legs against the floorboard? 􀂆 yes 􀂆 no

32: Was your ankle turned? 􀂆 yes 􀂆 no

33: Did the vehicle go into a spin or roll as a result of the impact? 􀂆 yes 􀂆 no

 If yes, explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

34: How much damage was there to the outside of the vehicle? 􀂆none 􀂆some 􀂆 a lot

35: How much damage was there to the inside of the vehicle? 􀂆none 􀂆some 􀂆a lot

36: At the point of impact, where did you experience pain? Be specific:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

37: Immediately after the accident were you: 􀂆 conscious 􀂆 dazed 􀂆 unconscious

38: If you lost consciousness, how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

39: Were you wearing a seat belt? 􀂆 yes 􀂆 no

40: Did the belt have a shoulder harness? 􀂆 yes 􀂆 no

 If yes, did it contribute to the pain you are experiencing? 􀂆 yes 􀂆 no

41: At the time of impact were you: 􀂆 looking straight ahead 􀂆 looking to the right

􀂆 looking to the left 􀂆 looking down 􀂆looking up

42: Did the seat break as a result of the impact? 􀂆 yes 􀂆 no

43: Were you braced for the impact? 􀂆 yes 􀂆 no

44: Were you surprised by the impact? 􀂆 yes 􀂆 no

45: Did you go to the hospital? 􀂆 yes 􀂆 no

46: If yes, when? 􀂆 right after the accident 􀂆 next day 􀂆 other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

47: If yes, how did you get there? 􀂆 ambulance other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

48: If by ambulance, did the ambulance attendants place you in a: 􀂆neck brace

􀂆 back brace 􀂆 other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

49: Any medication or medical supplies given? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

50: Did you have x-rays taken at the hospital? 􀂆 yes 􀂆 no

51: If you went to the hospital, please answer the following:

Name of hospital \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Treatment Received \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

52: Have you had any similar problems before? 􀂆 yes 􀂆 no

If yes, explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

53: Are you diabetic? 􀂆 yes 􀂆 no

54: Do you have high blood pressure? 􀂆 yes 􀂆 no

55: Do you have low blood pressure? 􀂆 yes 􀂆 no

56: Do you have arthritis or degenerative joint disease? 􀂆 yes 􀂆 no

57: What type of work do you do? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

58: What are your job requirements? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

59: Have you lost any days of work from this injury? 􀂆 yes 􀂆 no

If yes, give dates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_ Doctor Reviewed with Patient

Doctor Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_