

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: _____