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 collsion: □ head on □ rear end □ broad side □ front impact, rear ended car in front □ Other _____

Did the impact to your vehcile 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