Patient Name: _____ Date: _____

Motor Vehicle Collision Questionnaire

Date of Accident: _____ Location of Accident: _____

Questions about the accident circumstances:

Year and Make of vehicle you were riding in:

_____

Year and Make of other vehicle(s):

Vehicle 2: _____

Vehicle 3: _____

Monetary damage to your vehicle: $_____

Was there damage to other vehicles?

_____

Your head rest was adjusted to:

- ○ Top of Shoulder
- ○ Top of Ear
- ○ Top of Head

Were you the

- ○ Driver
- ○ Passenger

If passenger, where were you seated?

- ○ Passenger's seat
- ○ Rear seat, driver's side
- ○ Rear seat, passenger's side

Were you wearing a seat belt at the time?

○ Yes ○ No

Was your vehicle moving or stopped?

○ Moving ○ Stopped

Did your vehicle strike another vehicle?

○ Yes ○ No

Where was your vehicle hit?

- ○ In the front
- ○ In the rear
- ○ On the driver's side
- ○ On the passenger' side

Describe the collision: _____

_____

_____

If your vehicle had airbags, did they deploy?

○ Yes ○ No

What were the road conditions (circle)?

Dry Wet Icy Snow-packed

Other, *describe* _____

How far did your car move after impact?

Car lengths: _____

Feet: _____

Who was at fault for the accident? _____

Did the police write any tickets?

○ Yes ○ No

To Whom? _____

Questions about your circumstances at impact:

Were you aware of the impending impact?

○ Yes ○ No

If yes, did you brace yourself before the impact?

○ Yes ○ No

Were you looking in a mirror?

○ Yes ○ No

If yes, please describe:

_____

What was your body position at time of impact?

(Circle one)

○ Neutral ○ Forward ○ Rotated: Left / Right (circle one)

Did you strike another object?

○ Steering wheel ○ Dash ○ Window

Other: _____

Did you experience any of the following at the time of impact? (circle all the apply)

Cuts Bruises Bumps Nausea Dislocations

Immediate head pain Vision problems

Altered consciousness Immediate dizziness

Loss of consciousness*, how long*? _____

Immediate pain, *Where*? _____

Abrasions, *where*? _____

Questions about your circumstances after the accident:

Were you able to get out of the vehicle and walk on your own?

○ Yes ○ No

Was your car drivable from scene of accident?

○ Yes ○ No

Where did you go after the accident?

○ Home ○ Work ○ Hospital

If taken to a hospital answer the following questions:

Were you taken by ambulance?

○ Yes ○ No

Where? _____

Did you stay overnight? ○ Yes ○ No

If you went to a hospital, were any x-rays taken?

○ Yes ○ No

What areas of your body were x-rayed?

_____

How did you feel that night? (circle all that apply)

Restless In pain Stiff Sore Fine

How did you feel the next day?

○ Better ○ Same ○ Worse

Have you missed any time from work?

○ Yes ○ no

How much? _____