MOTOR VEHICLE COLLISION/PERSONAL INJURY QUESTIONNAIRE

Please answer all questions completely:

Your Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone #: _____ Work: _____ Cell Ph: _____

Age: _____ Date of Birth: _____ SS#: _____ E-mail: _____

Marital Status: ☐M ☐ S ☐ D ☐ W Drivers License # _____

Your Occupation: _____ Employed by: _____

Your Spouse's Name: _____

Name of person to contact in case of emergency: _____

Their home and work phone number: _____

Name of nearest relative not living with you: _____

Their phone number: _____

Referring Physician: _____

1. Please describe the collision in you own words:

   _____

   _____

   _____

2. Where did the collision occur? City/Town: _____ State: _____
3. Date of collision: _____ Time: _____ AM PM
4. Were you the: ☐ driver ☐ passenger ☐ pedestrian
5. If passenger, were you in the ☐ front seat ☐ right rear seat ☐ left rear seat
6. What type of vehicle were you in? _____
7. What type was the other vehicle? _____
8. Did your vehicle strike the other vehicle? ☐ yes ☐ no
9. Was your car struck by the other vehicle? ☐ yes ☐ no
10. What direction was your vehicle going? _____
11. What direction was the other vehicle going? _____
12. Was the impact from: ☐ the front ☐ the rear ☐ the left side ☐ the right side

Name_____ Date_____

MOTOR VEHICLE COLLISION/PERSONAL INJURY QUESTIONNAIRE Page 2

13. What was the approximate speed at the time of the impact?
    Your vehicle _____ mph Other vehicle _____ mph
14. What was the weather at the time of the collision? ☐ dry ☐ wet ☐ icy
15. Was your vehicle in: ☐ park ☐ neutral ☐ in gear ☐moving ☐stopped
16. Were your brakes being applied? ☐ yes ☐ no
17. Was your vehicle shoved: ☐ forward ☐ backward ☐ sideways
18. Were you shoved: ☐ forward ☐ whipped backward
19. Did your seat have a head restraint (headrest?) ☐ yes ☐ no
20. If yes, what was the position ☐ low ☐ midposition ☐ high
21. Did your head ride over the headrest? ☐ yes ☐no
22. Did your hat/glasses end up in the back seat or rear window? ☐ yes ☐ no
23. Did any other part of your body hit the interior of the vehicle? ☐ yes ☐ no
24. If yes, please specify: ☐ seatbelt restraints ☐ steering wheel ☐ dashboard
    ☐ windshield ☐ side door ☐ side window ☐ other _____
25. Which part of your body? ☐ chest ☐ head ☐ chin ☐ face ☐ R L knee
    ☐ R L shoulder ☐ R L hand ☐ other _____
26. Were you holding on to the steering wheel? ☐ yes ☐ no
27. Did you brace your arms against the dash? ☐ yes ☐ no
28. Did you brace your legs against the floorboard? ☐ yes ☐ no
29. Was your ankle turned? ☐ yes ☐ no
30. Did the vehicle go into a spin or roll as a result of the impact? ☐ yes ☐ no
31. If yes, explain: _____
32. How much damage was there to the outside of the vehicle? ☐ none ☐ some ☐ a lot
33. How much damage was there to the inside of the vehicle? ☐ none ☐ some ☐ a lot
34. At the point of impact, where did you experience pain? Be specific:

    _____

35. Immediately after the accident were you: ☐ conscious ☐ dazed ☐ unconscious
36. If you lost consciousness, how long? _____
37. Were you wearing a seat belt? ☐ yes ☐ no
38. Did the belt have a shoulder harness? ☐ yes ☐ no If yes, did it contribute to the pain you are experiencing? ☐ yes ☐ no

Name_____ Date_____

MOTOR VEHICLE COLLISION/PERSONAL INJURY QUESTIONNAIRE Page 3

39. At the time of impact were you: ☐ looking straight ahead ☐ looking to the right ☐ looking to the left ☐ looking down ☐looking up
40. Did the seat break as a result of the impact? ☐ yes ☐ no
41. Were you braced for the impact? ☐ yes ☐ no
42. Were you surprised by the impact? ☐ yes ☐ no
43. Did you go to the hospital? ☐ yes ☐ no
44. If yes, when? ☐ right after the accident ☐ next day ☐ other _____
45. If yes, how did you get there? ☐ ambulance other: _____
46. If by ambulance, did the ambulance attendants place you in a: ☐ neck brace ☐ back brace ☐ other _____
47. Any medication or medical supplies given? _____
48. Did you have x-rays taken at the hospital? ☐ yes ☐ no

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

    Name of hospital _____

    Name of doctor _____

    Diagnosis _____

    Treatment Received _____

    _____
49. Have you had any similar problems before? ☐ yes ☐ no
50. If yes, explain: _____
51. Are you diabetic? ☐ yes ☐ no
52. Do you have high blood pressure? ☐ yes ☐ no
53. Do you have low blood pressure? ☐ yes ☐ no
54. Do you have arthritis or degenerative joint disease? ☐ yes ☐ no
55. What type of work do you do? _____
56. What are your job requirements? _____
57. Have you lost any days of work from this injury? ☐ yes ☐ no

Name_____ Date_____

Present Complaints (please circle the appropriate ones) Page 4

Headache	Feet/hands cold	Head seems heavy	Pins and needles in arms Right / Left
Mental dullness	Depression	Confusion	
Loss of memory	Pins and needles in arms	Constipation	Pins and needles in hands Right / Left
Dizzy	Rib pain	Unbalanced	
Neck Pain	Neck stiffness	Chest pain	Pins and needles in legs Right / Left
Fainting	Shortness of breath	Ears ringing/buzzing	
Upper back pain	Upper back stiffness	Midback pain	Midback stiffness
Lower back pain	Lower back stiffness	Blurred vision	Double vision
Neck restriction	Eye strain / pain	Loss of taste	Loss of smell
Nervousness	Fear	Irritability	Tension

Difficulty in: ☐ Standing ☐ Sitting ☐ Bending ☐ Walking

Pain radiation to the: ☐ Right arm ☐ Left arm ☐ Right leg ☐ Left leg

Cannot lift: ☐ Light ☐ Moderate ☐Heavy ☐ Repetitive

Pain radiating to: ☐Neck ☐ Base of skull ☐ Ribs ☐ Shoulders ☐ Arms

Pain in the: ☐ Foot ☐ Ankle ☐ Knee ☐ Hip

OTHER SYMPTOMS: _____

_____

Since the time this (these) complaint(s) began, what, if anything, have you tried that **did not** work?

_____

Has the problem interrupted your sleep? Yes / No How: _____

Does anyone in your family have the same or similar condition: Yes / No

Who: _____

List any doctors or therapists that you have seen for **this** complaint:

1. _____ Specialty _____
2. _____ Specialty _____
3. _____ Specialty _____

Name_____ Date_____

List any operations that you've had and approximate dates:

1. _____ Date: _____ Dr: _____

2. _____ Date: _____ Dr: _____

3. _____ Date: _____ Dr: _____

Are you allergic to any medication? Please list: _____

_____

Are you taking any medications? Please list: _____

_____

Have you ever been in any **other** auto accident or **other** personal injury? ☐ Y ☐ N

Describe and give dates if possible:

_____

_____

Are you pregnant? ☐ Yes / ☐ No Due date: _____

Do you have a family physician? Name_____

Patient Signature _____ Date _____

Witness _____ Date _____

Print Name _____

Name_____ Date_____