

## Motor Vehicle Collision Questionnaire

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F Today's Date: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Telephone: \_\_\_\_\_ Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Wk. Ph: \_\_\_\_\_ Cell Ph: \_\_\_\_\_  
 Spouse's Name: \_\_\_\_\_ Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

YOUR Ins. Co.: \_\_\_\_\_ Claim #: \_\_\_\_\_  
 Policy #: \_\_\_\_\_ Adjuster's Name: \_\_\_\_\_ Phone#: \_\_\_\_\_  
 OTHER Vehicle Ins. Co.: \_\_\_\_\_ Claim #: \_\_\_\_\_  
 Policy #: \_\_\_\_\_ Adjuster's Name: \_\_\_\_\_ Phone#: \_\_\_\_\_

Who referred you to this clinic? \_\_\_\_\_  
 Have you retained an attorney?  Yes  No  
 If yes, Attorney's Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

### Nature of Collision

Date of Collision: \_\_\_\_\_ Time of Day: \_\_\_\_\_  
 Number of people in YOUR vehicle?: \_\_\_\_\_ Other vehicle?: \_\_\_\_\_  
 YOUR vehicle: Year \_\_\_\_\_ Make \_\_\_\_\_ Model \_\_\_\_\_  
 OTHER vehicle: Year \_\_\_\_\_ Make \_\_\_\_\_ Model \_\_\_\_\_  
 Were you the driver?  Yes  No If yes, was your foot on the brake?  Yes  No  
 If you were a passenger, where were you seated? \_\_\_\_\_  
 Were police notified?  Yes  No Was a DMV report made?  Yes  No  
 What is the estimated cost of damage to the vehicle you were in?: \_\_\_\_\_  
 Describe the details of how accident occurred: \_\_\_\_\_

What direction were YOU headed?  North  East  South  West on \_\_\_\_\_ (name of st.)  
 What direction was the OTHER VEHICLE headed?  North  East  South  West on \_\_\_\_\_  
 Road conditions:  Wet  Dry  Icy  
 Did you lose consciousness?  Yes  No If yes, for how long? \_\_\_\_\_  
 Exact areas of pain immediately after accident: \_\_\_\_\_  
 Any medical evaluation/care after accident?  Yes  No If yes, what? \_\_\_\_\_  
 Who was the practitioner? \_\_\_\_\_ Was diagnosis given? \_\_\_\_\_  
 Any prior injuries or symptoms to the same area(s)? If yes, please describe: \_\_\_\_\_  
 Has injury restricted your work?  Yes  No If yes, in what way? \_\_\_\_\_  
 Before this injury, were you able to work on an equal basis with others your age?  Yes  No

### **Check the symptoms you have noticed any time since the collision:**

#### **Circle the symptoms above you were presently experiencing.**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Headache                | <input type="checkbox"/> Restlessness                             | <input type="checkbox"/> Loss of smell       |
| <input type="checkbox"/> Neck pain               | <input type="checkbox"/> Nervousness                              | <input type="checkbox"/> Loss of taste       |
| <input type="checkbox"/> Forgetfulness           | <input type="checkbox"/> Sleeping Problems                        | <input type="checkbox"/> Lights bother eyes  |
| <input type="checkbox"/> Hard to concentrate     | <input type="checkbox"/> Heavy head                               | <input type="checkbox"/> Face flushed        |
| <input type="checkbox"/> Loss of memory          | <input type="checkbox"/> Tension                                  | <input type="checkbox"/> Chest pain          |
| <input type="checkbox"/> Disoriented             | <input type="checkbox"/> Dizziness                                | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Nausea                  | <input type="checkbox"/> Fainting                                 | <input type="checkbox"/> Cold sweat          |
| <input type="checkbox"/> Blurred vision          | <input type="checkbox"/> Irritability                             | <input type="checkbox"/> Stiff neck          |
| <input type="checkbox"/> Confusion               | <input type="checkbox"/> Depression                               | <input type="checkbox"/> Back/neck pain      |
| <input type="checkbox"/> Lightheadedness         | <input type="checkbox"/> Loss of balance                          | <input type="checkbox"/> cold hands/feet     |
| <input type="checkbox"/> Ringing/buzzing in ears | <input type="checkbox"/> Pins/needles in arms/legs                | <input type="checkbox"/> Upset stomach       |
| <input type="checkbox"/> Diarrhea                | <input type="checkbox"/> Constipation                             | <input type="checkbox"/> Fever               |
| <input type="checkbox"/> Fatigue                 | <input type="checkbox"/> Reduced tolerance to heat and/or alcohol |  |

**At the time of impact, your vehicle was:**

- Slowing down
- Stopped
- Gaining speed
- Moving at a constant or steady speed

**At the time of impact, the other vehicle was:**

- Slowing down
- Stopped
- Gaining speed
- Moving at steady speed
- Unknown speed
- Other:

**During and after the collision, your vehicle:**

- Kept going straight, not hitting anything
- Kept going straight, hitting car in front
- Was hit by another vehicle
- Spun around, not hitting anything
- Spun around, hitting another car
- Spun around, hitting object other than car

**Indicate if your body hit something or was hit by any of the following:**

Please draw lines from the body regions on the left side and match to the right side.

BODY PARTS HIT	OBJECT YOU HAD CONTACT WITH
Head	Windshield or side window
Face	Steering wheel
Shoulder	Side of door
Arm/Hand	Dashboard
Front chest wall	Knee bolster/glove compartment
Side chest wall	Seatbelt (lap belt or shoulder harness)
Hip/Abdomen	Frame of car near windows
Knee	Roof or top part of vehicle
Leg	Another occupant/animal
Foot	Other

**Check of any of the following vehicle parts broke, bent, or were damaged in your car:**

- Windshield
- Steering wheel
- Mirror
- Seat frame bent or damaged
- Side-rear window broken
- Other
- Knee bolster
- Dash

**All types of collisions:** Indicate those relevant to your case.

- |                          |                          |   |
|--------------------------|--------------------------|---|
| Yes                      | No                       |   |
| <input type="checkbox"/> | <input type="checkbox"/> | Did any of the interior front or side structures within your vehicle, such as the side door, dashboard, steering wheel, or floorboard of your car dent inward during the crash? |
| <input type="checkbox"/> | <input type="checkbox"/> | Did the side door, or interior of your vehicle touch or hit your body during the crash?   |
| <input type="checkbox"/> | <input type="checkbox"/> | Did your body slide under the seatbelt?   |
| <input type="checkbox"/> | <input type="checkbox"/> | Was the door(s) of your vehicle damaged to a point where you could not open the door?   |
| <input type="checkbox"/> | <input type="checkbox"/> | Did an airbag deploy in your vehicle during the crash? If yes, circle (side air bag/front air bag)  |
| <input type="checkbox"/> | <input type="checkbox"/> | Were you intoxicated (alcohol) at the time of crash?  |

See Reverse Side

**Seatbelt usage and steering wheel hand placement:**

Yes No

- Were you wearing a seatbelt?  
If yes, does your seatbelt have a:  lap and shoulder strap,  lap belt only
- Did you have any portion of your seatbelt positioned behind your chest, back or shoulder?
- Were you holding onto the steering wheel (driver only) at the time of impact?  
If yes, indicate where each hand was positioned (*Use time clock face as your reference point*)  
**Left hand:**  Not on wheel,  Yes, hand at \_\_\_ o'clock,  Hand elsewhere  
**Right hand:**  Not on wheel,  Yes, hand at \_\_\_ o'clock,  Hand elsewhere

**Describe your vehicle's head restraint system:**

- Movable/adjustable head restraint  Fixed, non-movable head restraint
- No headrests in my vehicle  Bench seat in your vehicle without head restraint

**Please indicate how your head restraint was positioned at the time of crash (if present):**

- At the top of the back of your head  Midway height of the back of your head
- Lower height of the back of your head  Located at the level of your neck
- Level of your shoulder blades

**Bruising after the crash:**

Yes No

- Did your body have any bruising (areas that were visibly black, red and/or blue) after the crash? If yes, indicate where bruising was located on your body and what caused the bruising:

\_\_\_\_\_

**Awareness and body position descriptions:** Check all areas that apply to you.

- You were unaware of the impending collision. You did not see or hear brakes prior to the impact.
- You were aware of the impending crash and relaxed before the collision.
- You were aware of the impending crash and braced yourself.
- Your body, torso, and head were facing straight ahead.
- You had your head and/or torso turned at the time of collision:  
 Turned to left,  Turned to right  
Describe how far you were turned /twisted and why you were turned/what were you doing?

\_\_\_\_\_

- You were leaning forward at the time of impact, resulting in a gap between your body and the seatback. If yes, indicate how far you were leaning and why you were leaning forward.
- Your torso/body were positioned normally against the seatback with no gaps due to leaning/twisting.

**How soon did you first notice any pain/soreness after the crash?**

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

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_