

MOTOR VEHICLE COLLISION/PERSONAL INJURY 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?
Your vehicle _____ mph Other vehicle _____ mph
16. What was the weather at the time of the collision? dry wet icy
17. Was your vehicle in: park neutral in gear moving stopped
18. Were your brakes being applied? yes no
19. Was your vehicle shoved: forward backward sideways
20. Were you shoved: forward whipped backward
21. Did your seat have a head restraint (headrest?) yes no

22. If yes, what was the position low midposition high
23. Did your head ride over the headrest? yes no
24. Did your hat/glasses end up in the back seat or rear window? yes no
25. Did any other part of your body hit the interior of the vehicle? yes no
26. If yes, please specify: seatbelt restraints steering wheel dashboard
 windshield side door side window other _____
27. Which part of your body? chest head chin face R L knee
 R L shoulder R L hand other _____
28. Were you holding on to the steering wheel? yes no
29. Did you brace your arms against the dash? yes no
30. Did you brace your legs against the floorboard? yes no
31. Was your ankle turned? yes no
32. Did the vehicle go into a spin or roll as a result of the impact? yes no
33. 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
41. If yes, did it contribute to the pain you are experiencing? yes no
42. At the time of impact were you: looking straight ahead looking to the right
 looking to the left looking down looking up
43. Did the seat break as a result of the impact? yes no
44. Were you braced for the impact? yes no
45. Were you surprised by the impact? yes no
46. Did you go to the hospital? yes no
47. If yes, when? right after the accident next day other _____

48. If yes, how did you get there? ambulance other: _____

49. If by ambulance, did the ambulance attendants place you in a: neck brace
 back brace other _____

50. Any medication or medical supplies given? _____

51. 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 _____

52. Have you had any similar problems before? yes no

53. If yes, explain: _____

54. Are you diabetic? yes no

55. Do you have high blood pressure? yes no

56. Do you have low blood pressure? yes no

57. Do you have arthritis or degenerative joint disease? yes no

58. What type of work do you do? _____

59. What are your job requirements? _____

60. Have you lost any days of work from this injury? yes no

61. If yes, give dates: _____

Patient Signature _____ Date _____

Witness _____ Date _____

Print Name _____