**MOTOR VEHICLE ACCIDENT QUESTIONAIRRE**

Patient Name: _____ Date: _____ Acct. #: _____

Date of Accident: _____ Time of Accident: _____

City/County/State where accident happened: _____

Type of Vehicles involved in accident: Yours _____ Other Vehicle: _____

Your position in Vehicle: ☐ Driver ☐ Front middle ☐ Passenger ☐ Back left ☐ Back middle ☐ Back Right
☐ Pedestrian that was hit by vehicle.

**DESCRIPTION OF THE ACCIDENT:**

**Your vehicle was:**

☐ Crossing an intersection
☐ Stopped at an intersection
☐ Stopped for a crossing pedestrian
☐ Stopped in traffic
☐Traveling at the posted speed
☐ Traveling faster than the speed limit
☐ Traveling slower than the speed limit
☐ Turning left
☐ Turning right
☐ Heading North
☐ Heading Northeast
☐ Heading Northwest
☐ Heading South
☐ Heading Southeast
☐ Heading Southwest
☐ Heading East
☐ Heading West

**Your car was:**

☐ Hit head on
☐ Hit on the front right
☐ Hit on the front left
☐ Hit on the rear right
☐ Hit on the rear left
☐ Rear-ended
☐ Side swiped on the left
☐ Side swiped on the right
☐ Hit the other car head on
☐ Hit the other car on the front right
☐ Hit the other car on the front left
☐ Hit the other car on the right rear
☐ Hit the other car on the left rear
☐ Rear – ended the other car
☐ Side swiped the other car on the left
☐ Side swiped the other car on the right

**Amount of damage to your car:**
☐ Complete ☐ Extensive ☐ Minimal ☐ Moderate

**Speed of your car at time of impact:** _____

**Amount of damage to other car:**
☐ Complete ☐ Extensive ☐ Minimal ☐ Moderate

**Speed of other car at time of impact:** _____

**Weather condition**: ☐ Clear ☐ Cloudy ☐ Drizzling ☐ Foggy ☐ Rainy ☐ Snowing ☐ Stormy ☐ Sunny

**Road condition**: ☐ Damp ☐ Dry ☐ Dry with icy patches ☐ Iced over ☐ Snowed over ☐ Wet

**Visibility**: ☐ Fair ☐ Good ☐ Poor

**DESCRIBE THE MOMENT OF IMPACT**

**Body position at impact:**

☐ Leaning forward
☐ Slouched down in the seat
☐ Sitting straight
☐ Turned to the left
☐ Turned to the right
☐ Holding on to the steering wheel.
☐ Bracing your arms against the dash
☐ Bracing your feet against the floor
☐ Not holding on the steering wheel
☐ Not bracing arms against the dash
☐ Not bracing feet against the floor

**Vehicle was pushed**: ☐ Forward ☐ Backward ☐ Sideways

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**Type of passive restraint**: ☐ Lap belt ☐ Shoulder belt ☐ Lap and Shoulder belt

**Direction body was thrown**:

| | | |
|---|---|---|
| ☐ Backward then forward | ☐ To the right | ☐ Under the vehicle |
| ☐ Forward then backward | ☐ About the vehicle | |
| ☐ To the left | ☐ Outside the vehicle | |

Head position at impact: ☐ Straight ☐ Tilted forward ☐ Turned left ☐ Turned right

Direction head was thrown: ☐ Backward then forward ☐ Forward then backward ☐ Side to side

Position of headrest: ☐ High position ☐ Low position ☐ Middle position ☐ Not installed.

Did the vehicle go into a spin or roll as a result of the accident? ☐ Yes ☐ No

Were the breaks being applied? ☐ Yes ☐ No

Did the airbags deploy? ☐ Yes ☐ No

Was your ankle turned? ☐ Yes ☐ No

Did your head ride over the headrest? ☐ Yes ☐ No

Did you hit anything in the vehicle? ☐ Yes ☐ No

**If yes what did you hit:**
☐ Dashboard ☐ Windshield ☐ Door ☐ Seat ☐ Steering wheel ☐ Ceiling ☐ Loose objects ☐ Side window

**What body part(s) hit**:

| | | | |
|---|---|---|---|
| ☐ Head | ☐ Right arm | ☐ Right wrist | ☐ Right knee |
| ☐ Left shoulder | ☐ Left elbow | ☐ Left hip | ☐ Left ankle |
| ☐ Right shoulder | ☐ Right elbow | ☐ Right hip | ☐ Right ankle |
| ☐ Left arm | ☐ Left wrist | ☐ Left knee | |

**<u>WHAT HAPPENED IMMEDIATELY FOLLOWING THE ACCIDENT?</u>**

**Initial Reaction**:
☐ Shaken ☐ Upset ☐ Nervous ☐ Confused ☐ Frightened ☐ Dazed ☐ Distressed ☐ Dizzy ☐ Weak

**Where did you have pain**?

| | | | |
|---|---|---|---|
| ☐ Head | ☐ Left forearm | ☐ Abdomen | ☐ Right shin |
| ☐ Neck | ☐ Right wrist | ☐ Low back | ☐ Left shin |
| ☐ Right shoulder | ☐ Left wrist | ☐ Pelvis | ☐ Right foot |
| ☐ Left shoulder | ☐ Right hand | ☐ Right buttock | ☐ Left foot |
| ☐ Right arm | ☐ Left hand | ☐ Left buttock | |
| ☐ Left arm | ☐ Rib cage | ☐ Right leg | |
| ☐ Right elbow | ☐ Chest | ☐ Left leg | |
| ☐ Left elbow | ☐ Upper back | ☐ Right knee | |
| ☐ Right forearm | ☐ Mid back | ☐ Left knee | |

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**Did you receive any cuts**?

| | | | |
|---|---|---|---|
| ☐ Head | ☐ Right forearm | ☐ Upper back | ☐ Left leg |
| ☐ Neck | ☐ Left forearm | ☐ Mid back | ☐ Right knee |
| ☐ Right shoulder | ☐ Right wrist | ☐ Abdomen | ☐ Left knee |
| ☐ Left shoulder | ☐ Left wrist | ☐ Low back | ☐ Right shin |
| ☐ Right arm | ☐ Right hand | ☐ Pelvis | ☐ Left shin |
| ☐ Left arm | ☐ Left hand | ☐ Right buttock | ☐ Right foot |
| ☐ Right elbow | ☐ Rib cage | ☐ Left buttock | ☐ Left foot |
| ☐ Left elbow | ☐ Chest | ☐ Right leg | |

**What type of emergency care was provided**?

☐ Bandaging ☐ Bracing ☐ CPR ☐ A neck collar ☐ Splinting

**Immediate destination after accident**? ☐ Work ☐ Home ☐ School ☐ Hospital ☐ Clinic ☐ Doctors office

**If taken to a hospital or clinic, name**: _____

**If seen by a physician, name**: _____

**Diagnoses**: _____

If admitted to hospital date admitted: _____ Date discharged: _____

**Diagnostic exams performed**: ☐ X-ray ☐ CAT scan ☐ MRI

**Area of body diagnostic exam performed on:**

| | | | |
|---|---|---|---|
| ☐ Head | ☐ Right forearm | ☐ Upper back | ☐ Left leg |
| ☐ Neck | ☐ Left forearm | ☐ Mid back | ☐ Right knee |
| ☐ Right shoulder | ☐ Right wrist | ☐ Abdomen | ☐ Left knee |
| ☐ Left shoulder | ☐ Left wrist | ☐ Low back | ☐ Right shin |
| ☐ Right arm | ☐ Right hand | ☐ Pelvis | ☐ Left shin |
| ☐ Left arm | ☐ Left hand | ☐ Right buttock | ☐ Right foot |
| ☐ Right elbow | ☐ Rib cage | ☐ Left buttock | ☐ Left foot |
| ☐ Left elbow | ☐ Chest | ☐ Right leg | |

**Treatment administered:**

| | | |
|---|---|---|
| ☐ Adjustments | ☐ Hot packs | ☐ Supports |
| ☐ Bandaging | ☐ Ice packs | ☐ Surgery |
| ☐ Bracing | ☐ Injection | ☐ Sutures |
| ☐ Casting | ☐ Oral medications | ☐ Topical antiseptics |
| ☐ A collar | ☐ Splinting | |

**Medications prescribed:**

| | | |
|---|---|---|
| ☐ Antibiotics | ☐ Herbal | ☐ Pain medication |
| ☐ Anti-inflammatory | ☐ Muscle relaxant | |
| ☐ Anxiety | ☐ Over the counter | |

**Recommendations:**

| | | |
|---|---|---|
| ☐ See a chiropractor | ☐ See a neurologist | ☐ Time off work |
| ☐ No further treatment | ☐ See a orthopedic surgeon | ☐ Use cervical collar |
| ☐ Rest | ☐ Physical Therapy | ☐ Use supports |
| ☐ See a general practitioner | ☐ Ice packs | |
| ☐ See a general surgeon | ☐ Heat packs | |