

MOTOR VEHICLE ACCIDENT QUESTIONNAIRE

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

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

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

Direction body was thrown:

- | | | |
|--|--|--|
| <input type="checkbox"/> Backward then forward | <input type="checkbox"/> To the right | <input type="checkbox"/> Under the vehicle |
| <input type="checkbox"/> Forward then backward | <input type="checkbox"/> About the vehicle | |
| <input type="checkbox"/> To the left | <input type="checkbox"/> 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:

- | | | | |
|---|--------------------------------------|--------------------------------------|--------------------------------------|
| <input type="checkbox"/> Head | <input type="checkbox"/> Right arm | <input type="checkbox"/> Right wrist | <input type="checkbox"/> Right knee |
| <input type="checkbox"/> Left shoulder | <input type="checkbox"/> Left elbow | <input type="checkbox"/> Left hip | <input type="checkbox"/> Left ankle |
| <input type="checkbox"/> Right shoulder | <input type="checkbox"/> Right elbow | <input type="checkbox"/> Right hip | <input type="checkbox"/> Right ankle |
| <input type="checkbox"/> Left arm | <input type="checkbox"/> Left wrist | <input type="checkbox"/> Left knee | |

WHAT HAPPENED IMMEDIATELY FOLLOWING THE ACCIDENT?

Initial Reaction:

- Shaken Upset Nervous Confused Frightened Dazed Distressed Dizzy Weak

Where did you have pain?

- | | | | |
|---|---------------------------------------|--|-------------------------------------|
| <input type="checkbox"/> Head | <input type="checkbox"/> Left forearm | <input type="checkbox"/> Abdomen | <input type="checkbox"/> Right shin |
| <input type="checkbox"/> Neck | <input type="checkbox"/> Right wrist | <input type="checkbox"/> Low back | <input type="checkbox"/> Left shin |
| <input type="checkbox"/> Right shoulder | <input type="checkbox"/> Left wrist | <input type="checkbox"/> Pelvis | <input type="checkbox"/> Right foot |
| <input type="checkbox"/> Left shoulder | <input type="checkbox"/> Right hand | <input type="checkbox"/> Right buttock | <input type="checkbox"/> Left foot |
| <input type="checkbox"/> Right arm | <input type="checkbox"/> Left hand | <input type="checkbox"/> Left buttock | |
| <input type="checkbox"/> Left arm | <input type="checkbox"/> Rib cage | <input type="checkbox"/> Right leg | |
| <input type="checkbox"/> Right elbow | <input type="checkbox"/> Chest | <input type="checkbox"/> Left leg | |
| <input type="checkbox"/> Left elbow | <input type="checkbox"/> Upper back | <input type="checkbox"/> Right knee | |
| <input type="checkbox"/> Right forearm | <input type="checkbox"/> Mid back | <input type="checkbox"/> Left knee | |

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

Did you receive any cuts?

- | | | | |
|---|--|--|-------------------------------------|
| <input type="checkbox"/> Head | <input type="checkbox"/> Right forearm | <input type="checkbox"/> Upper back | <input type="checkbox"/> Left leg |
| <input type="checkbox"/> Neck | <input type="checkbox"/> Left forearm | <input type="checkbox"/> Mid back | <input type="checkbox"/> Right knee |
| <input type="checkbox"/> Right shoulder | <input type="checkbox"/> Right wrist | <input type="checkbox"/> Abdomen | <input type="checkbox"/> Left knee |
| <input type="checkbox"/> Left shoulder | <input type="checkbox"/> Left wrist | <input type="checkbox"/> Low back | <input type="checkbox"/> Right shin |
| <input type="checkbox"/> Right arm | <input type="checkbox"/> Right hand | <input type="checkbox"/> Pelvis | <input type="checkbox"/> Left shin |
| <input type="checkbox"/> Left arm | <input type="checkbox"/> Left hand | <input type="checkbox"/> Right buttock | <input type="checkbox"/> Right foot |
| <input type="checkbox"/> Right elbow | <input type="checkbox"/> Rib cage | <input type="checkbox"/> Left buttock | <input type="checkbox"/> Left foot |
| <input type="checkbox"/> Left elbow | <input type="checkbox"/> Chest | <input type="checkbox"/> 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:

- | | | | |
|---|--|--|-------------------------------------|
| <input type="checkbox"/> Head | <input type="checkbox"/> Right forearm | <input type="checkbox"/> Upper back | <input type="checkbox"/> Left leg |
| <input type="checkbox"/> Neck | <input type="checkbox"/> Left forearm | <input type="checkbox"/> Mid back | <input type="checkbox"/> Right knee |
| <input type="checkbox"/> Right shoulder | <input type="checkbox"/> Right wrist | <input type="checkbox"/> Abdomen | <input type="checkbox"/> Left knee |
| <input type="checkbox"/> Left shoulder | <input type="checkbox"/> Left wrist | <input type="checkbox"/> Low back | <input type="checkbox"/> Right shin |
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| <input type="checkbox"/> Left arm | <input type="checkbox"/> Left hand | <input type="checkbox"/> Right buttock | <input type="checkbox"/> Right foot |
| <input type="checkbox"/> Right elbow | <input type="checkbox"/> Rib cage | <input type="checkbox"/> Left buttock | <input type="checkbox"/> Left foot |
| <input type="checkbox"/> Left elbow | <input type="checkbox"/> Chest | <input type="checkbox"/> Right leg | |

Treatment administered:

- | | | |
|--------------------------------------|---|--|
| <input type="checkbox"/> Adjustments | <input type="checkbox"/> Hot packs | <input type="checkbox"/> Supports |
| <input type="checkbox"/> Bandaging | <input type="checkbox"/> Ice packs | <input type="checkbox"/> Surgery |
| <input type="checkbox"/> Bracing | <input type="checkbox"/> Injection | <input type="checkbox"/> Sutures |
| <input type="checkbox"/> Casting | <input type="checkbox"/> Oral medications | <input type="checkbox"/> Topical antiseptics |
| <input type="checkbox"/> A collar | <input type="checkbox"/> Splinting | |

Medications prescribed:

- | | | |
|--|---|--|
| <input type="checkbox"/> Antibiotics | <input type="checkbox"/> Herbal | <input type="checkbox"/> Pain medication |
| <input type="checkbox"/> Anti-inflammatory | <input type="checkbox"/> Muscle relaxant | |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Over the counter | |

Recommendations:

- | | | |
|---|---|--|
| <input type="checkbox"/> See a chiropractor | <input type="checkbox"/> See a neurologist | <input type="checkbox"/> Time off work |
| <input type="checkbox"/> No further treatment | <input type="checkbox"/> See a orthopedic surgeon | <input type="checkbox"/> Use cervical collar |
| <input type="checkbox"/> Rest | <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> Use supports |
| <input type="checkbox"/> See a general practitioner | <input type="checkbox"/> Ice packs | |
| <input type="checkbox"/> See a general surgeon | <input type="checkbox"/> Heat packs | |