Kristin Rabai, DC
3537 Thaxton Ave SE, Albuquerque, NM 87106
(505) 514-4150

Motor Vehicle Collision Questionaire

Name_____Date of Birth_____Today's Date_____

Date of Collision_____Time_____(AM/PM) State_____

Driver of Vehicle_____Where were you seated?_____

Type of Collision: ( ) Head-on ( ) Broad-side ( ) Rear-end ( ) Front impact, rear-ended vehicle in front
( ) Non-Collision (Describe):_____

Describe in your own words what happened to you upon impact:_____

_____

Does your vehicle have headrests? Yes/No If yes, what was the position of the headrest compared to your head?: ( ) Top of headrest even with bottom of head
( ) Top of headrest even with top of head
( ) Top of headrest even with middle of neck

Was your car moving at the time of the collision? Yes/No If yes, how fast would you estimate that you were going?_____m.p.h. (estimate) How fast was the other vehicle travelling?_____m.p.h. (estimate)

Was your vehicle breaking? Yes/No
Were seat belts worn? Yes/No
Did you brace for impact? Yes/No
Were shoulder harnesses worn? Yes/No

Head/body position at time of impact:
( ) Head turned left/right
( ) Head looking back
( ) Head straight forward
( ) Body straight in sitting position
( ) Body rotated left/right
( ) Other:_____

At the time of the collision, recall what parts of your head or body hit what parts on the inside of your vehicle:

_____

As a result of the collision you were: ( ) Rendered unconscious ( ) dazed, circumstances vague ( ) Other:

_____

Could you move all parts of your body? Yes/No If no, what parts and why?_____

_____

Were you able to get out of the car and walk unaided? Yes/No If no, why not?_____

_____

What bleeding cuts did you get from this collision?_____

What bruises did you get from this collision?_____

Please describe how you felt immediately after the collision. Please be specific._____

_____

Later that ( ) day ( ) night:_____

The next day:_____

Check symptoms apparent <u>since</u> the collision:

( ) Headache	( ) Loss of smell	( ) Numbness in fingers
( ) Neck pain/stiffness	( ) Loss of taste	( ) Cold hands
( ) Mid back pain	( ) Loss of memory	( ) Cold feet
( ) Low back pain	( ) Fatigue	( ) Diarrhea
( ) Eyes sensitive to light	( ) Tension	( ) Constipation
( ) Pain behind eyes	( ) Shortness of breath	( ) Chest pain
( ) Dizziness	( ) Irritability	( ) Nervousness
( ) Fainting	( ) Depression	( ) Cold sweats
( ) Ringing/buzzing in ear/s	( ) Sleeping problems	( ) Anxious
( ) Loss of balance	( ) Numbness in toes	( ) Other:_____

Have you missed time from work? Yes/No If yes, describe how many days_____
( ) Unable to work since collision
Did you go to seek medical help immediately / soon after the collision? Yes/No If yes, how did you get there?
( ) Someone else drove me ( ) Drove own vehicle ( ) Ambulance ( ) Police ( ) Other:_____

Doctor / Hospital / Clinic seen:_____

Were you examined? Yes/No Were Xrays taken? Yes/No _____

What treatment was given to you?_____

What benefits did you receive from the treatment?_____

Date of last treatment?_____Have you sought or had any other care other than who you listed above?_____

Did you have any physical complaints just before the collision? Yes/No If yes, please describe in detail:

_____

Name_____Date of Birth;_____Date of Loss_____

Kristin Rabai, DC
3537 Thaxton Ave SE, Albuquerque, NM 87106
(505) 514-4150