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Motor Vehicle Collision Questionnaire

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 braking? 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 since the collision:

- | | | |
|---|--|--|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Loss of smell | <input type="checkbox"/> Numbness in fingers |
| <input type="checkbox"/> Neck pain/stiffness | <input type="checkbox"/> Loss of taste | <input type="checkbox"/> Cold hands |
| <input type="checkbox"/> Mid back pain | <input type="checkbox"/> Loss of memory | <input type="checkbox"/> Cold feet |
| <input type="checkbox"/> Low back pain | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Eyes sensitive to light | <input type="checkbox"/> Tension | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Pain behind eyes | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Chest pain |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Irritability | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Depression | <input type="checkbox"/> Cold sweats |
| <input type="checkbox"/> Ringing/buzzing in ear/s | <input type="checkbox"/> Sleeping problems | <input type="checkbox"/> Anxious |
| <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Numbness in toes | <input type="checkbox"/> 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 _____