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Motor Vehicle Collision Questionnaire

Name:_____ Date:_____

Date of collision:_____ Time of collision:_____ AM PM

Person at fault:_____

Insurance Co:_____ Claim#:_____

Address:_____
Street City State Zip Code

Attorney name(if applicable):_____ Phone:_____

Address:_____
Street City State Zip Code

Specific collision location(street/intersection):_____

Did the police come to the accident scene? ☐ Yes ☐ No Make a written report? ☐ Yes ☐ No

Were any photographs taken of the vehicle? ☐ Yes ☐ No

Was your car drivable/totaled:_____

How did the collision occur?_____

_____

_____

_____

Collision description-type (Check all that apply):

☐ Single-vehicle crash	☐ Head-on collision	☐ Rollover
☐ Two-vehicle crash	☐ Rear-end collision	☐ Ran off the road
☐ Multiple-vehicle crash	☐ Side collision	☐ Hit guard rail, tree, object
Other(Describe):		

After the initial impact the car (Check all that apply):

☐ Kept going straight	☐ Spun around	
☐ Hit another car	☐ Was hit by another car	☐ Hit an object(guard rail, tree,etc)

Make, model and year of vehicle you were in:_____

Make, model and year of the other vehicle:_____

Where was your vehicle hit?_____

How fast were you traveling?_____ How fast was the other vehicle traveling?_____

Where were you seated in the vehicle?_____

Were you wearing a seatbelt?_____ If yes, which? ☐ Lapbelt ☐ Shoulder strap ☐ Both

Does your car have headrests? ☐ Yes ☐ No If yes, were they? ☐ At head level ☐ Below head level ☐ Above head level

Did the vehicle airbags deploy? ☐ Yes ☐ No If yes, which airbags? ☐ Front ☐ Side ☐ Both

Were you aware of the impending collision? ☐ Yes ☐ No At the time of impact were you? ☐ Braced ☐ Relaxed

Head/body position at the time of impact (Check all that apply):

Head	☐ Looking straight ahead	☐ Looking to the side ☐ Left ☐ Right	☐ Against the headrest ☐ Away from headrest
Body	☐ Straight ahead	☐ Twisted to the side ☐ Left ☐ Right	☐ Against the seat back ☐ Away from seat back
Hands/Arms	☐ Both hands on steering wheel	☐ Left hand on wheel ☐ Left hand elsewhere	☐ Right hand on wheel ☐ Right hand elsewhere

Were you taken to the hospital? Where?_____

Were X-ray/MRI/CT scans taken since the collision? Where?_____

_____

Are you also under the care of another physician as a result of this collision? ☐ Yes ☐ No

Physician name and address_____

Did your body impact the inside of the vehicle? Where?_____

_____

Immediate pain following the collision? Where?_____

_____

Describe current pain/areas of complaint:_____

_____

_____

Did you have bruising after the collision? Where?_____

_____

Symptom list **(Check all that apply)**	**Began less than 24 hours after collision**	**Began 1-7 days after collision**	**Had symptoms recently before the collision**	**Had similar symptoms one year or more before the collision**
Headache/Migraine				
Dizziness				
Tinnitus(Ear ringing)				
Blurry vision				
Memory/concentration problems				
Nausea or vomiting				
Balance/coordination problems				
Sensitivity to sound or light				
Pain/Difficulty swallowing				
Jaw pain/soreness				
Neck pain/soreness				
Pain radiating down arms				
Arm tingling/numbness				
Weakness in arms/legs				
Shoulder pain/bruising/soreness				
Elbow pain/soreness				
Wrist, hand, finger pain/numbness				
Upper or middle back pain/soreness				
Chest pain or bruising				
Rib cage pain or bruising				
Abdominal-pelvic pain or bruising				
Low back pain/soreness				
Pain radiating down leg(s)				
Leg numbness/tingling				
Hip pain/bruising				
Upper leg or thigh pain/soreness				
Lower leg or calf pain/soreness				
Knee pain/soreness				
Ankle, foot or toe pain/soreness				
Other				

Please mark your areas of pain on the figures below.