## MOTOR VEHICLE COLLISION/PERSONAL INJURY QUESTIONNAIRE Please answer all questions completely: 1. Your name and address: 2. Phone Number: 3. Please describe the collision in your own words: 4. Where did the collision occur? City/Town: \_\_\_\_\_\_ State: \_\_\_\_ Time: 5. Date of collision: AM PM 6. Were you the: ☐ driver ☐ passenger ☐ pedestrian 7. If passenger, were you in the \( \Box \) front seat \( \Box \) right rear seat \( \Box \) left rear seat 8. What type of vehicle were you in? 9. What type was the other vehicle? 10. Did your vehicle strike the other vehicle? ☐ yes ☐ no 11. Was your car struck by the other vehicle? ☐ yes ☐ no 12. What direction was your vehicle going? 13. What direction was the other vehicle going? 14. Was the impact from: ☐ the front ☐ the rear ☐ the left side ☐ the right side 15. What was the approximate speed at the time of the impact? Your vehicle \_\_\_\_\_ mph Other vehicle \_\_\_\_\_ mph 16. What was the weather at the time of the collision? ☐ dry ☐ wet ☐ icy □moving □stopped 17. Was your vehicle in: ☐ park ☐ neutral ☐ in gear 18. Were your brakes being applied? ☐ yes ☐ no

19. Was your vehicle shoved: ☐ forward ☐ backward ☐ sideways

21. Did your seat have a head restraint (headrest?) ☐ yes ☐ no

20. Were you shoved: ☐ forward ☐ whipped backward

22. If yes, what was the position ☐ low ☐ midposition ☐ high
23. Did your head ride over the headrest? ☐ yes ☐ no
24. Did your hat/glasses end up in the back seat or rear window? ☐ yes ☐ no
25. Did any other part of your body hit the interior of the vehicle?
26. If yes, please specify: ☐ seatbelt restraints ☐ steering wheel ☐ dashboard
☐ windshield ☐ side door ☐ side window ☐ other
27. Which part of your body? ☐ chest ☐ head ☐ chin ☐ face ☐ R L knee
☐ R L shoulder ☐ R L hand ☐ other
28. Were you holding on to the steering wheel? ☐ yes ☐ no
29. Did you brace your arms against the dash? ☐ yes ☐ no
30. Did you brace your legs against the floorboard? ☐ yes ☐ no
31. Was your ankle turned? ☐ yes ☐ no
32. Did the vehicle go into a spin or roll as a result of the impact? ☐ yes ☐ no
33. If yes, explain:
34. How much damage was there to the outside of the vehicle? ☐ none ☐ some ☐ a lot
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48. If yes, how did you get there? □ ambulance other:  49. If by ambulance, did the ambulance attendants place you in a: □ neck brace □ back brace □ other  50. Any medication or medical supplies given?  51. Did you have x-rays taken at the hospital? □ yes □ no If you went to the hospital, please answer the following:  Name of doctor  Name of doctor
Treatment Received
52. Have you had any similar problems before?  yes no 53. If yes, explain: 54. Are you diabetic?  yes no 55. Do you have high blood pressure?  yes no 56. Do you have low blood pressure?  yes no 57. Do you have arthritis or degenerative joint disease?  yes no 58. What type of work do you do? 59. What are your job requirements? 60. Have you lost any days of work from this injury? yes no 61. If yes, give dates:
Patient Signature Date
Print Name Date