



MOTOR VEHICLE ACCIDENT QUESTIONNAIRE

PATIENT NAME _____ DATE OF BIRTH _____

- Date of Accident? _____ Time of Accident? _____
- Location of Accident: _____
- In your own words, how did the accident occur? _____

- Were you the driver or a passenger in the automobile? _____. If you were a passenger, what position were you sitting in the automobile? _____
- How many people were in your vehicle? _____ Other vehicle(s)? _____
- What is the make, model and year of your automobile? _____
- What is the make, model and year of the other vehicle(s) _____
- What were the road surface conditions (dry, wet, snow, ice, etc.)? _____
- How fast were you traveling? _____; The other vehicle? _____
- What type of damage was done to your vehicle? _____
- What type of damage was done to the other involved vehicle(s)? _____
- Were you aware the accident was going to occur, did you see it coming? ___ Yes ___ No
- Did you hear any tires screeching? ___ Yes ___ No
- If you struck the vehicle in front of you, did you hit it straight on, off to the left or off to the right? _____
- If you were hit from behind, was the impact more from the center, or more to the left or right? _____
- Was your foot on the brake at the time of impact? ___ Yes ___ No. If yes, did your car move forward after impact? ___ Yes ___ No
- Where did your vehicle end up after the accident? (I.e. did not move, moved slightly, ended in a ditch, etc.) _____
- Where did the other involved automobile(s) end up after the accident?

- Did anything in the vehicle strike you? ___ Yes ___ No. If yes, what and where?

- What was the position of your head (looking/turned to the left/right, looking straight ahead, looking in the rearview mirror etc.)? _____
- What was the position of your hands on the steering wheel at the time of the accident? (i.e. 10 & 2 o'clock) _____
- What was the position of your legs/feet? _____
- Were you sitting straight up? ___ Yes ___ No. If you weren't, were you leaning to the side (Right or Left), slumped in your chair, etc.? _____
- What was the distance from the back of your head to the headrest? (____ inches)? What was the height of your headrest? _____
- Were you wearing the appropriate seat restraints? ___ Yes ___ No. Were you wearing: shoulder restraints, lap restraints or both? _____
- If you were wearing eyeglasses/sunglasses, did they remain on your face? ___ Yes ___ No. Did you have to readjust your glasses after impact? ___ Yes ___ No.
- Were you wearing any accessories on your head? ___ Yes ___ No. Were the accessories still on your head after the accident? ___ Yes ___ No. What accessories are you referring to? _____
- Do you have any pictures of your vehicle following the accident? ___ Yes ___ No
- Do you remember your head being whipped back and forth? ___ Yes ___ No If yes, which direction was your head whipped? _____
- Did your head strike anything in the vehicle? ___ Yes ___ No. If yes, what? _____
- Were your airbags released? ___ Yes ___ No
- Did you have to be extricated out of the vehicle? ___ Yes ___ No. Were you able to get out of the car on your own? ___ Yes ___ No
- Were you taken from the accident via ambulance? ___ Yes ___ No. Were you examined and/or treated by an emergency medical crew at the site of the accident? ___ Yes ___ No If you went to the hospital, whether via ambulance or on your own, where were you taken? _____
- Have you been examined/treated by any other health care providers? ___ Yes ___ No. If yes, please tell us who?/when?/where?/how often?/etc. _____

- Have you been prescribed any medications for conditions sustained in this motor vehicle accident? Yes or No. If yes, what have you been prescribed? _____

- Have you had any special studies (x-rays, CAT scans, MRI's, etc.) performed for this accident? Yes or No. If yes, what? _____

- Did you have any visible injuries immediately after the accident? Yes or No. If yes, what? _____ Do you have any pictures of the visible injuries? __Yes __ No. If this is more than 3 days after the accident, have you noticed any bruising on your body? __Yes or __No. If yes, where? _____
- Have you ever been involved in a motor vehicle accident in the past? If yes, what date? _____ Nature of the accident _____
- Do you remember everything from the time of the impact until after the impact? __Yes __ No. Did you lose consciousness as a result of the accident? __Yes __ No.
- Have you noticed any visual disturbances as a result of the accident? __Yes __ No. Have you had any ringing of the ears? __Yes __ No. Anything else? _____
- Were you nauseated as a result of the accident? __Yes __ No. Did you vomit within the first 24 hours following the accident __Yes __ No. Were you dizzy? __Yes __ No.
- Are you experiencing any jaw pain? __Yes __ No. Right / Left / Bilateral.
- What symptoms do you have as a result of the accident (i.e. neck/back pain, arm/leg pain, headaches, extremity complaints, etc.)? _____

Describe your pain i.e. burning, sharp dull, etc. _____

Do you have any radiating arm or leg pain? __Yes __No.

- Are you symptoms? __Getting Worse __Staying the same __Getting Better
- Does anything make your pain better or worse?
Describe: _____
- Is your pain worse with coughing, sneezing or going to the bathroom? __Yes __No.
- Have there been any changes in bowel/bladder function since the accident? __Yes __ No.
- Are you having any problems with memory or concentration as a result of your motor vehicle accident? __Yes __ No. Describe: _____
- Did you hear anything pop, snap or tear during or after the accident? __Yes __ No.
- What is your current pain level (0-10 scale), with 0 being no pain and 10 being the worst pain that you could ever imagine? _____/10 When you feel the best, what is your pain level? _____/10 When you feel the worst, what is your pain level? _____/10.

- Are your current symptoms with you 25%, 50%, 75% or 100% of the time...Mark down which symptoms are with you via those percentages?

100% _____

75% _____

50% _____

25% _____

- Did you have any complaints prior to the accident you were involved in? Yes No.
If yes, list these areas and write what the pain level (1 to 10) was prior to the motor vehicle accident at its best, worst, average

- Have you worked since the accident? Yes No; If yes, FT PT Intermittent
- If yes to above, are you on limited duty? Yes No. Describe: _____
- Are you having difficulty performing your daily activities? Yes No. If yes, what are you having difficulty performing? _____

- Are you having difficulty sleeping since the accident? Yes No. Describe:

- Is there anything else we have not asked you that you feel is pertinent to this case?

Patient's Printed Name: _____

Patient's Social Security Number: _____

I have answered the above truthfully and to the best of my knowledge,

Patient Signature _____ Date _____

Provider Signature _____ Date _____

Revised: 03.05.03