101 E 5th St. Suite 227 St. Paul, MN 55101

MOTOR VEHICLE COLLISION 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: _____

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

6: Were you the: □ driver □ passenger □ pedestrian

7: If passenger, were you in the □ front seat □ right rear seat □ 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?

16: Your vehicle _____ mph Other vehicle _____ mph

17: What was the weather at the time of the collision? □ dry □ wet □ icy

18: Was your vehicle in: □ park □ neutral □ in gear □moving □stopped

19: Were your brakes being applied? □ yes □ no

20: Was your vehicle shoved: □ forward □ backward □ sideways

21: Were you shoved: □ forward □ whipped backward

22: Did your seat have a head restraint (headrest?) □ yes □ no

23: If yes, what was the position □ low □ mid-position □ high

Patient Name: _____ Date: _____

24: Did your head ride over the headrest? □ yes □no

25: Did your hat/glasses end up in the back seat or rear window? □ yes □ no

26: Did any other part of your body hit the interior of the vehicle? □ yes □ no

27: If yes, please specify: □ seatbelt restraints □ steering wheel □ dashboard □ windshield □ side door □ side window □ other _____

28: Which part of your body? □ chest □ head □ chin □ face □ R L knee □ R L shoulder □ R L hand □ other _____

29: Were you holding on to the steering wheel? □ yes □ no

30: Did you brace your arms against the dash? □ yes □ no

31: Did you brace your legs against the floorboard? □ yes □ no

32: Was your ankle turned? □ yes □ no

33: Did the vehicle go into a spin or roll as a result of the impact? □ yes □ no

If yes, explain: _____

34: How much damage was there to the outside of the vehicle? □none □some □ a lot

35: How much damage was there to the inside of the vehicle? □none □some □a lot

36: At the point of impact, where did you experience pain? Be specific:

_____

37: Immediately after the accident were you: □ conscious □ dazed □ unconscious

38: If you lost consciousness, how long? _____

39: Were you wearing a seat belt? □ yes □ no

40: Did the belt have a shoulder harness? □ yes □ no

If yes, did it contribute to the pain you are experiencing? □ yes □ no

41: At the time of impact were you: □ looking straight ahead □ looking to the right □ looking to the left □ looking down □looking up

42: Did the seat break as a result of the impact? □ yes □ no

43: Were you braced for the impact? □ yes □ no

44: Were you surprised by the impact? □ yes □ no

45: Did you go to the hospital? □ yes □ no

46: If yes, when? □ right after the accident □ next day □ other _____

47: If yes, how did you get there? □ ambulance other: _____

Patient Name: _____ Date: _____

48: If by ambulance, did the ambulance attendants place you in a: □neck brace

□ back brace □ other _____

49: Any medication or medical supplies given? _____

50: Did you have x-rays taken at the hospital? □ yes □ no

51: If you went to the hospital, please answer the following:

Name of hospital _____

Treatment Received _____

52: Have you had any similar problems before? □ yes □ no

If yes, explain: _____

53: Are you diabetic? □ yes □ no

54: Do you have high blood pressure? □ yes □ no

55: Do you have low blood pressure? □ yes □ no

56: Do you have arthritis or degenerative joint disease? □ yes □ no

57: What type of work do you do? _____

58: What are your job requirements? _____

59: Have you lost any days of work from this injury? □ yes □ no

If yes, give dates: _____

Patient Name: _____ Date: _____

_____ Doctor Reviewed with Patient

Doctor Signature: _____ Date:_____

Proactive Healthcare