

MOTOR VEHICLE ACCIDENT QUESTIONNAIRE



Patient Name: _____ Date: _____

1. What was the date of the accident? _____

2. What time did the accident occur? _____

3. How many vehicles were involved in the accident? _____

4. What was the estimated damage to the vehicle you were in? _____

5. What state did the accident occur in? _____

6. What city did the accident occur in? _____

7. What street or intersection were you on when the accident occurred? _____

8. What direction were you traveling in? _____

9. What type of impact was the auto accident? _____

10. Did your vehicle hit anything after the accident? If yes, please describe:

11. Where were you sitting in the vehicle during the accident? _____

12. Did you know the accident was coming? _____

13. What type of vehicle were you in? _____

14. What type of vehicle impacted yours? _____

15. At the time of impact, how fast was your vehicle moving? _____

16. At the time of impact, how fast was the other vehicle moving? _____

17. During and after the crash, what happened to your vehicle? (circle all that apply)

- kept going straight

- spun around

- kept going straight hitting a car in front

- spun around and hit a stationary object

- was hit by another vehicle

- hit a stationary object

18. Did you lose consciousness during the accident? no yes

19. How was your head positioned during the accident? _____

20. How was your torso positioned during the accident? _____

21. How were your hands positioned during the accident? _____

22. Did your head hit anything during the accident? no yes - please describe: _____

23. Did your face hit anything during the accident? no yes - please describe: _____

24. Did your shoulders hit anything during the accident? no yes - please describe: _____

25. Did your neck hit anything during the accident? no yes - please describe: _____

26. Did your chest hit anything during the accident? no yes - please describe: _____

27. Did your hips hit anything during the accident? no yes - please describe: _____

28. Did your knees hit anything during the accident? no yes - please describe: _____

29. Did your feet hit anything during the accident? no yes - please describe: _____

30. What kind of headrest was in your vehicle?

- movable fixed headrest
- nonmovable fixed headrest
- no headrest

31. Where was the headrest positioned on your head? _____

32. Did you have your seatbelt on during the accident? no yes

33. Did you slide out of your seatbelt during the accident? no yes

34. What was damaged in your vehicle? (circle all that apply)

- | | | |
|------------------|--------------------|-----------------------|
| - windshield | - rear bumper | - mirror |
| - steering wheel | - front bumper | - knee bolster |
| - dashboard | - trunk | - back right door |
| - seat frame | - front left door | |
| - side window | - front right door | - completely totalled |
| - rear window | - back left door | |

35. Choose the items that dented inward:

- | | | |
|---------------|-------------|-------------|
| - floorboards | - side door | - dashboard |
|---------------|-------------|-------------|

36. Choose the doors that would not open as a result of the accident:

- | | |
|--------------|---------------|
| - front left | - front right |
| - rear left | - rear right |

37. Did you go to the hospital? no yes

If no, why? (AND DO NOT ANSWER 38-43) _____

38. How did you get to the hospital? _____

39. What was the name of the hospital? _____

40. Were you hospitalized over night? _____

41. Circle what you were prescribed at the hospital:

- | | | |
|-------------------|-------------------|--------------|
| - pain medication | - muscle relaxers | - neck brace |
|-------------------|-------------------|--------------|

42. Did you receive any stitches for any cuts at the hospital? _____

43. Were x-rays taken at the hospital? no yes

If yes, which area was taken? _____

Patient Signature: _____ Date: _____