



## MOTOR VEHICLE ACCIDENT QUESTIONNAIRE

*Thank you in advance for taking the time to complete this form, this will help us to better assess all of your pain concerns and provide you with the best treatment.*

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

Date of Injury: \_\_\_\_\_ Age: \_\_\_\_\_

### Accident Details:

1. What kind of vehicle were you in?:

Year - \_\_\_\_\_

Make - \_\_\_\_\_

Model - \_\_\_\_\_

2. Where were you seated? (circle): Driver / Front passenger / Rear left / Rear right

3. Were you wearing your seat belt? (circle): Yes / No

4. Did the airbags deploy? (circle): Yes / No

5. What was your body position at impact? (circle):

-Looking straight / Looking right / Looking left / \_\_\_\_\_

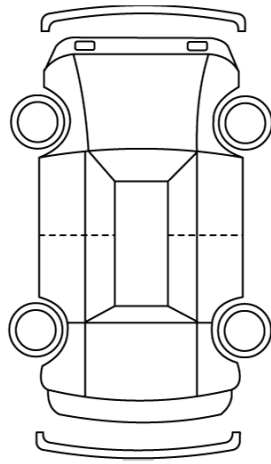
-Both hands on wheel / Right hand on wheel / Left hand on wheel / Hands in lap

-Right foot on brake / Right foot on gas / Left foot on floorboard / Both feet on floorboard

6. Where was the damage to your vehicle?:

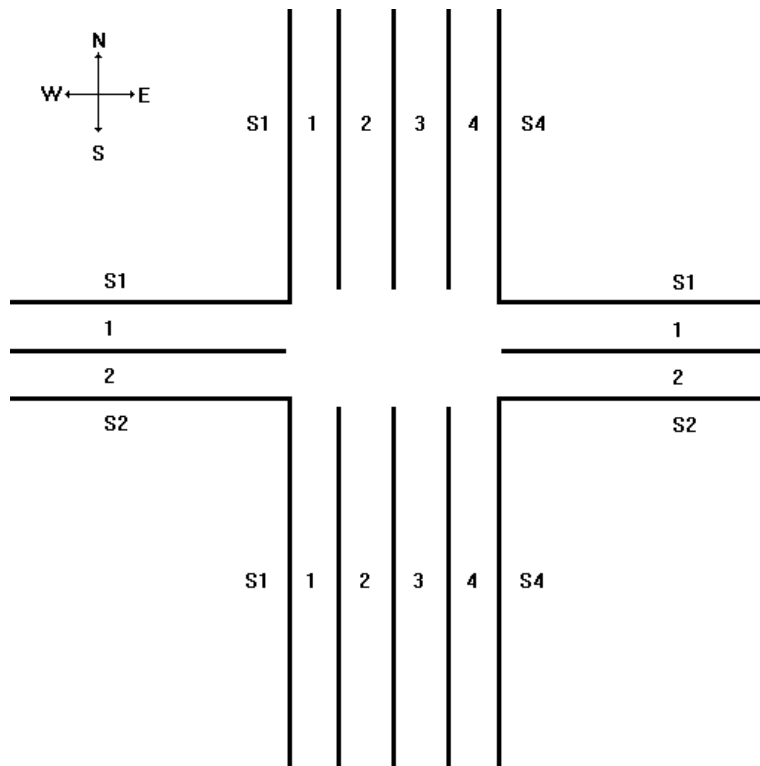
Front: Driver Side

Passenger Side



7. What kind of vehicle struck you?: \_\_\_\_\_

8. If possible, please roughly draw out what happened in the accident:



9. How fast was your vehicle traveling? (approximately): \_\_\_\_\_ mph

10. How fast was the other vehicle traveling? (approximately): \_\_\_\_\_ mph

11. Were you prepared for the impact, did you brace yourself? (circle): Yes / No

12. Did you lose consciousness? (circle): Yes / No

13. Were you in a daze, felt dizzy, disoriented, confused, etc ?. (circle): Yes / No

a. How long? \_\_\_\_\_ (ex. couple of seconds, 5 minutes, etc.)

\*\*\*If you answered **YES** to either **question 12 or 13**, please fill out question 13a\*\*\*

14. Where did you go for medical treatment?: \_\_\_\_\_

15. Were you taken by ambulance? (circle): Yes / No

13a. After a head injury or accident some people experience symptoms which can cause worry or nuisance. We would like to know if you **now suffer** from any of the symptoms given below. As many of these symptoms occur normally, we would like you to compare yourself now with before the accident. For each one, **please circle the number closest to your answer.**

0 = Not experienced at all, 1 = No more of a problem, 2 = A mild problem,

3 = A moderate problem, 4 = A severe problem

Compared with before the accident, do you now (i.e., over the last 24 hours) suffer from:

Headaches.....	0	1	2	3	4
Feelings of Dizziness .....	0	1	2	3	4
Nausea and/or Vomiting .....	0	1	2	3	4
Noise Sensitivity, easily upset by loud noise	0	1	2	3	4
Sleep Disturbance .....	0	1	2	3	4
Fatigue, tiring more easily .....	0	1	2	3	4
Being Irritable, easily angered .....	0	1	2	3	4
Feeling Depressed or Tearful .....	0	1	2	3	4
Feeling Frustrated or Impatient .....	0	1	2	3	4
Forgetfulness, poor memory .....	0	1	2	3	4
Poor Concentration .....	0	1	2	3	4
Taking Longer to Think .....	0	1	2	3	4

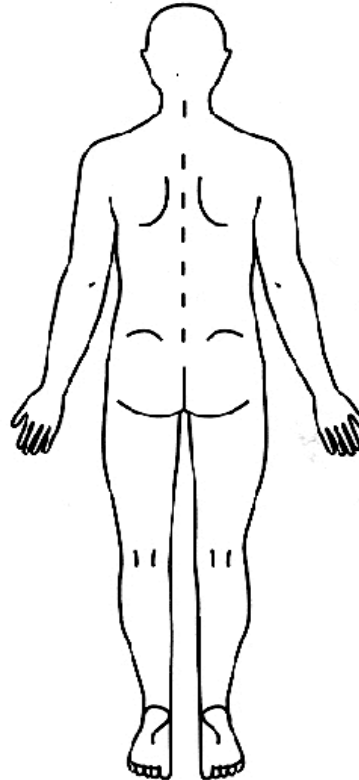
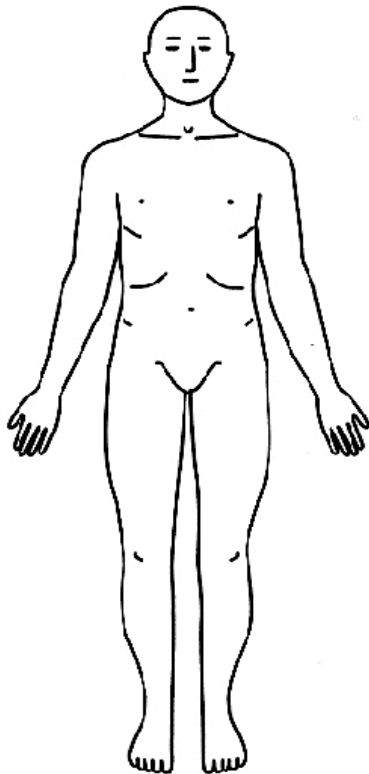
Blurred Vision .....	0	1	2	3	4
Light Sensitivity, Easily upset by bright light	0	1	2	3	4
Double Vision .....	0	1	2	3	4
Restlessness .....	0	1	2	3	4
<i>Are you experiencing any other difficulties? (please list)</i>					
1. _____	0	1	2	3	4
2. _____	0	1	2	3	4

Please take a moment to specifically identify your pain:

**B2. Pain drawing**

Mark the areas on your body where you feel the described sensations. Use the appropriate symbol. Mark areas of radiation. Include all affected areas.

Numbness	—	INC Sensitivity	0000
Constant	xxx	Sharp Twinge	///
Throbbing Ache	xxx		





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Have you missed work? (circle): Yes / No

-If yes, how much: \_\_\_\_\_

-Have you returned to work?d (circle): Yes / No

-Have you **EVER** been in another **motor vehicle, work or any other type of injury?**

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

**MEDICAL CONDITIONS** (Please list: such as diabetes, depression, gastric reflux):

\_\_\_\_\_

**MEDICATIONS** (Tylenol, ibuprofen, Motrin, Alleve): \_\_\_\_\_

\_\_\_\_\_

**SURGERIES:** \_\_\_\_\_

\_\_\_\_\_

**ALLERGIES:** \_\_\_\_\_

**FAMILY HISTORY:**

FATHER – age \_\_\_\_\_, alive ( circle): Yes / No

- medical conditions: \_\_\_\_\_

MOTHER – age \_\_\_\_\_, alive (circle): Yes / No

- medical conditions: \_\_\_\_\_

**SOCIAL HISTORY:**

Tobacco use (circle): Yes / No

Alcohol use (circle): Yes / Social / No

Drug use (circle): Yes / No

**REVIEW OF SYSTEMS:** *(mark only if positive)*

**General-**

Weight loss or gain

Fatigue

Fever or chills

**Skin-**

Rashes

Dryness

Lumps

**Head-**

Headache

Head injury

**Ears-**

Decreased hearing

Ringing in ears

Earache

**Eyes-**

Glasses or contacts

Blurry or double vision

Flashing lights

**Nose-**

Discharge

Itching

Nosebleeds

**Neck-**

Lumps

Swollen glands

**Cardiovascular-**

Chest pain

Tightness

Palpitations

**Respiratory-**

- Coughing up blood
- Shortness of breath
- Painful breathing

**Musculoskeletal-**

- Muscle or joint pain
- Redness of joints
- Swelling of joints

**Gastrointestinal-**

- Constipation / Diarrhea
- Change in appetite
- Nausea

**Neurologic-**

- Dizziness
- Fainting
- Seizures

**Urinary-**

- Increased Frequency
- Incontinence
- Blood in urine

**Psychiatric-**

- Nervousness
- Depression
- Memory loss

*Thank you!*

*Office use:* \_\_\_\_\_