Motor Vehicle Collision Information

Your Name:	**Today's Date:**

Date of your Accident:	**Time of Accident:**	**Do You Have the Accident Report?____**

Your Location in the Vehicle	**Were You the Driver or Passenger?** ☐ Driver ☐ Passenger		
	If You Were a Passenger:	Location (circle one)	Front Seat / Middle Row / Back Seat/ Row
		Position (circle one)	Left (Driver's Side) / Middle / Right Side

Your Vehicle -- Information About Your Vehicle:

Describe Your Vehicle and the Road Conditions	**Type :**	Car / Van / Truck / Bus / SUV / Motorcycle / Taxi / Other:
	Size :	Subcompact / Compact Car or Truck / Mid Size / Full Size Car or Truck
	Action :	Completely Stopped / Slowing / Accelerating / Driving – Estimate Speed: _____MPH
	Time of Day:	Daytime / Dawn / Dusk / Night
	Road Condition :	Dry / Damp / Wet / Snow / Ice

-- Enter the Information for the Other Vehicles or Objects Involved --

What Was the First Vehicle or Object That Collided With Your Car?

(Select one)	****If the first impact was not a vehicle – What Object Impacted Your Car?:**	
☐ **Vehicle**	**Vehicle Type :**	Car / Van / Truck / Bus / SUV / Motorcycle / Other:
	Size :	Subcompact / Compact Car or Truck / Mid Size / Full Size Car or Truck
☐ **Object**	**Damage to That Vehicle:**	$ _____ / Minimal / Moderate / Extensive / Totaled / Don't Know
How did it collide with your car? Hit your Front / Hit your Rear / Right Side / Left Side / Other:		

If There Was a Second Impact, What Was the Second Vehicle or Object That Collided With Your Car?

(Select one)	****If the second impact was not a vehicle – What Object Impacted Your Car?:**	
☐ **Vehicle**	**Vehicle Type :**	Car / Van / Truck / Bus / SUV / Motorcycle / Other:
	Size :	Subcompact / Compact Car or Truck / Mid Size / Full Size Car or Truck
☐ **Object**	**Damage to That Vehicle:**	Minimal / Moderate / Extensive / Totaled / Don't Know
How did it collide with your car? Hit your Front / Hit your Rear / Right Side / Left Side / Other:		

If There Was a Third Impact, What Was the Third Vehicle or Object That Collided With Your Car?

(Select one)	****If the third impact was not a vehicle – What Object Impacted Your Car?:**	
☐ **Vehicle**	**Vehicle Type :**	Car / Van / Truck / Bus / SUV / Motorcycle / Other:
	Size :	Subcompact / Compact Car or Truck / Mid Size / Full Size Car or Truck
☐ **Object**	**Damage to Third Vehicle:**	Minimal / Moderate / Extensive / Totaled / Don't Know
How did it collide with your car? Hit your Front / Hit your Rear / Right Side / Left Side / Other:		

Other Important Information:

Were You Wearing a Seat Belt?	☐ Yes	☐ No	Did the Car Have Air Bags?	☐ Yes	☐ No
Did the Air Bag Deploy?	☐ Yes	☐ No	Was Your Seat Back Broken?	☐ Yes	☐ No
Was the Seat Back Position Changed?	☐ Yes	☐ No	Prepared for the Impact? ☐ Yes, Braced for it	☐ No, Unexpected	

Seat Head Rest Position : (Circle one)	Low / Mid / High / None / Don't Know
Head and Body Position : (Circle one)	Straight / Rotated Left / Rotated Right / Unsure / Other:
Body Thrown From Vehicle?	☐ Yes / ☐ No / ☐ No, but I was thrown out of my seat in the car

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All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Body Impact (Indicate all the parts of your body that were struck during the impact)

☐ Head ☐ Upper Back/ Chest	☐ Right Arm/ Hand	☐ Left Arm/ Hand	☐ Right Shoulder ☐ Left Shoulder
☐ Right Knee ☐ Left Knee	☐ Right Foot/ Ankle	☐ Left Foot/ Ankle	☐ Other:

After the Accident Information:

Immediately after the accident, how were you? Check all that apply.	☐ Dizzy/dazed ☐ Weak ☐ Nervous ☐ Headache ☐ Disoriented ☐ Unconscious ☐/Other:

Medical Treatment After the Accident (Medical care for this accident before coming to our office)

Any Medical Care?	☐ No	☐ Yes You Drove Yourself? / Went in an Ambulance? / Other:

Time of Your Care	At time of Accident / Later that Day / Next day / _____ Days Later: (Specify)
You Went To	Hospital E.R. / Urgent Care Center / Chiropractor / Family Doctor / Other:
Were You Admitted to the Hospital?	☐ No ☐ Yes - How Many Days Spent in Hospital:
Tests Done on You:	☐ X-rays _____ ☐ Lab Work ☐ MRI or CT Scan_____ ☐ Other: _____
Treatments:	☐ Ice Pack ☐ Hot Pack ☐ None ☐ Cervical Collar ☐ Medication ☐ Other:_____
Other Doctors Seen Since Your Accident	

Later Symptoms You Experienced - (Please note any symptoms that started after the accident occurred)

Head Symptoms	☐ Headache ☐ Dizziness ☐ Blurred Vision ☐ Light Headedness ☐ Loss of Vision ☐ Fainting ☐ Loss of Memory ☐ Pain in ear ☐ Double Vision ☐ Other Specify:
Other Areas of **Pain**	☐ Neck ☐ Upper Back ☐ Mid Back/ Chest ☐ Low Back ☐ Buttock or Hip Joint ☐ Shoulder Joint ☐ Upper Arm ☐ Forearm ☐ Hand/ fingers ☐ Knee ☐ Ankle ☐ Foot/ Toes Other Specify:
Area of **Numbness** or **Tingling**	☐ Neck ☐ Upper Back ☐ Mid Back/ Chest ☐ Low Back ☐ Buttock or Hip Joint ☐ Shoulder Joint ☐ Upper Arm ☐ Forearm ☐ Hand/ fingers ☐ Knee ☐ Ankle ☐ Foot/ Toes Other Specify:
What Other Problems Have You Had Since Your Accident?	☐ Nervousness ☐ Fatigue ☐ Irritable ☐ Depressed ☐ Generally Feel Rundown ☐ Prostate Pain/Swelling ☐ Difficulty Urinating ☐ Night Urination ☐ Cramping ☐ Irregularity Loss of Sleep : [_____] hrs per night Loss of weight : [_____] lbs Gained weight : [_____] lbs Other: _____ _____

We Need to Know About Previous Accidents or Injuries You've Had:

Tell Us About Any Previous Injuries / Accidents You Have Had:	☐ No Significant Accident/ Injuries ☐ Yes, Specify When and What Injuries: _____ _____
Did You Have Residual Pain or Permanent Injury From a Previous Injury or Accident?	☐ No ☐ Yes, Specify: _____ _____

Signature of Patient or Adult Guardian: _____ **Date:** _____

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