



Motor Vehicle Collision Questionnaire

Name: _____ Date: _____

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

Person at fault: _____

Insurance Co: _____ Claim#: _____

Address: _____
Street City State Zip Code

Attorney name(if applicable): _____ Phone: _____

Address: _____
Street City State Zip Code

Specific collision location(street/intersection): _____

Did the police come to the accident scene? Yes No Make a written report? Yes No

Were any photographs taken of the vehicle? Yes No

Was your car drivable/totaled: _____

How did the collision occur? _____

Collision description-type (Check all that apply):

<input type="checkbox"/> Single-vehicle crash	<input type="checkbox"/> Head-on collision	<input type="checkbox"/> Rollover
<input type="checkbox"/> Two-vehicle crash	<input type="checkbox"/> Rear-end collision	<input type="checkbox"/> Ran off the road
<input type="checkbox"/> Multiple-vehicle crash	<input type="checkbox"/> Side collision	<input type="checkbox"/> Hit guard rail, tree, object
Other(Describe): _____		

After the initial impact the car (Check all that apply):

<input type="checkbox"/> Kept going straight	<input type="checkbox"/> Spun around	
<input type="checkbox"/> Hit another car	<input type="checkbox"/> Was hit by another car	<input type="checkbox"/> Hit an object(guard rail, tree,etc)

Make, model and year of vehicle you were in: _____

Make, model and year of the other vehicle: _____

Where was your vehicle hit? _____

How fast were you traveling? _____ How fast was the other vehicle traveling? _____

Where were you seated in the vehicle? _____

Were you wearing a seatbelt? _____ If yes, which? Lapbelt Shoulder strap Both

Does your car have headrests? Yes No If yes, were they? At head level Below head level Above head level

Did the vehicle airbags deploy? Yes No If yes, which airbags? Front Side Both

Were you aware of the impending collision? Yes No At the time of impact were you? Braced Relaxed

Head/body position at the time of impact (Check all that apply):

Head	<input type="checkbox"/> Looking straight ahead	<input type="checkbox"/> Looking to the side <input type="checkbox"/> Left <input type="checkbox"/> Right	<input type="checkbox"/> Against the headrest <input type="checkbox"/> Away from headrest
Body	<input type="checkbox"/> Straight ahead	<input type="checkbox"/> Twisted to the side <input type="checkbox"/> Left <input type="checkbox"/> Right	<input type="checkbox"/> Against the seat back <input type="checkbox"/> Away from seat back
Hands/Arms	<input type="checkbox"/> Both hands on steering wheel	<input type="checkbox"/> Left hand on wheel <input type="checkbox"/> Left hand elsewhere	<input type="checkbox"/> Right hand on wheel <input type="checkbox"/> Right hand elsewhere

Were you taken to the hospital? Where? _____

Were X-ray/MRI/CT scans taken since the collision? Where? _____

Are you also under the care of another physician as a result of this collision? Yes No

Physician name and address _____

Did your body impact the inside of the vehicle? Where? _____

Immediate pain following the collision? Where? _____

Describe current pain/areas of complaint: _____

Did you have bruising after the collision? Where? _____

Symptom list (Check all that apply)	Began less than 24 hours after collision	Began 1-7 days after collision	Had symptoms recently before the collision	Had similar symptoms one year or more before the collision
Headache/Migraine				
Dizziness				
Tinnitus(Ear ringing)				
Blurry vision				
Memory/concentration problems				
Nausea or vomiting				
Balance/coordination problems				
Sensitivity to sound or light				
Pain/Difficulty swallowing				
Jaw pain/soreness				
Neck pain/soreness				
Pain radiating down arms				
Arm tingling/numbness				
Weakness in arms/legs				
Shoulder pain/bruising/soreness				
Elbow pain/soreness				
Wrist, hand, finger pain/numbness				
Upper or middle back pain/soreness				
Chest pain or bruising				
Rib cage pain or bruising				
Abdominal-pelvic pain or bruising				
Low back pain/soreness				
Pain radiating down leg(s)				
Leg numbness/tingling				
Hip pain/bruising				
Upper leg or thigh pain/soreness				
Lower leg or calf pain/soreness				
Knee pain/soreness				
Ankle, foot or toe pain/soreness				
Other				

Please mark your areas of pain on the figures below.

