Motor Vehicle Collision Questionnaire

Lakeville Chiropractic

Name:_____ **Date:**____/____/_____
Date of injury:____/___/____ **Location of injury(town/city):**_____

How did the accident occur? Please answer the following:
1. What type of vehicle were you in? _____
2. Were you wearing a seat belt? **Y / N** 3. Were you the **driver or passenger**? Did your air bag deploy? **Y / N**
4. If passenger, was it the **front / rear / right / left / middle**?
5. Approximately how fast was your vehicle moving? _____MPH
6. Was your vehicle struck: **head on / rear ended/ broadside (R) (L).**
7. Which parts of the vehicle collided? _____
8. What type of vehicle struck you? _____
9. If applies: how fast was the other vehicle moving? _____MPH
10. Did wet or icy road, fog, etc. contribute to the collision? **Y / N** If yes,explain _____
11. Did non-prescription drugs or alcohol contribute to the collision? **Y / N** If so,explain_____
12. Did you brace for impact? **Y / N** If yes: how? **Hands on steering wheel / dash/ etc.**
13. Was your head or body turned at impact? **Y / N** If yes, how? _____
14. Describe how the collision occurred: _____

_____

_____

Symptoms immediately following the collision: **(neck/low back/head ache/ numbness/etc.**
Please describe in detail: _____

_____

Medical treatment following the collision and past medical history:
1. Were you taken by ambulance? **Y / N** 2. Were you treated at a hospital? **Y / N**
Where? _____ When?_____ How did you get there?_____
3. What treatment was rendered? **(examination / x-rays / cervical collar /medication)**? _____

_____

Have you sought additional medical treatment since the accident other than the initial treatment? **Y / N** If yes, where? _____
Have the symptoms changed since the initial injury? How? _____

_____

Have you had any specialized testing **(MRI/CAT scan/EMG)**? **Y / N** If yes, what tests were done, location, date.

_____

Did you have any similar symptoms prior to the collision? **Y / N** If yes, describe. _____

_____

Have you had a previous automobile collision, fall or other trauma? **Y / N** If yes, explain. _____

_____

Do you have any health related problems or take medication (**hypertension, diabetes, etc**.) If yes, explain.

_____

Work History:
Have you lost any time from work since the injury? **Y / N** If yes, give dates: _____
What are your normal duties at work? _____
Does your job require any of the following?

- Prolonged sitting? Y / N
- Prolonged bending? Y / N
- Prolonged standing? Y / N
- Repetitive lifting? Y / N
- Awkward postures? Y / N
- Heavy lifting? Y / N If yes, how much weight? _____

Do you have an attorney representing you? **Yes / No** If yes, who? _____