

ADVANCED CHIROPRACTIC & REHABILITATION

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MOTOR VEHICLE COLLISION/PERSONAL INJURY QUESTIONNAIRE

1. Your name and address: _____ Phone number: Home _____
Work _____
Cell _____

Date of Birth: _____ Occupation: _____

2. Date of collision: _____ 3. Hour of Accident: _____ AM / PM

4. Please describe how the collision happened: _____

5. Where did the collision occur? (Intersection or Cross Street) _____

6. What was your position in the car? (Circle) **Driver / Front Passenger / Left Rear / Right Rear**

7. If "Driver", were your hands on the steering wheel? **Both / Left / Right**

8. Did the airbags deploy? **Yes / No**

9. Did you strike another vehicle? **Yes / No** Did another vehicle strike your vehicle? **Yes / No**

10. Angle of impact: **Front / Back / Left / Right / Other:** _____

11. If Second Collision – Angle of 2nd impact: **Front / Back / Left / Right / Other** _____

12. In relation to the back of your head, was your headrest set: **Low / Middle / High**

13. Were you surprised by the impact? **Yes / No**

14. If "NO", how did you brace? **With Hands / With Feet**

15. Where was your head facing at the time of impact? **Straight Ahead / Left / Right / Behind**

16. Were you leaning forward at the time of impact? **Yes / No**

17. What type and year of vehicle were you in? _____
18. What was the approximate speed of your vehicle when the accident occurred? _____ **mph**
19. What type and year of vehicle struck yours? _____
20. What was the approximate speed of the other vehicle when the accident occurred? _____ **mph**
21. Were you wearing a seatbelt? **Yes / No** What type? **Lap Belt / Shoulder Belt / Both**
22. Did you feel pain immediately after the accident? **Yes / No**
23. Were you rendered unconscious as a result of the accident? **Yes / No**
24. Did you strike anything in the vehicle at the time of impact? **Yes / No** If "YES", specify what part of your body struck what: (i.e. head, chest, chin, shoulder, knee, etc.)
- | | |
|---|--|
| <input type="checkbox"/> Steering Wheel _____ | <input type="checkbox"/> Windshield _____ |
| <input type="checkbox"/> Dashboard _____ | <input type="checkbox"/> Roof _____ |
| <input type="checkbox"/> Left Side Door _____ | <input type="checkbox"/> Right Side Door _____ |
| <input type="checkbox"/> Left Window _____ | <input type="checkbox"/> Right Window _____ |
| <input type="checkbox"/> Other _____ | |
25. Did your seat break or bend? **Yes / No**
26. Immediately after the accident, how did you feel? (Circle all that apply)
Dizzy / Dazed / Weak / Upset / Disoriented / Nervous / Nauseous / Other _____
27. Was the accident reported to the police? **Yes / No**
28. Were traffic citations issued? **Yes / No** If "YES", to whom? _____
29. Did you go to the hospital? **Yes / No** If "YES", when? _____
- If "YES", how did you get there? Ambulance / Police Car / Private Transportation
30. Were you admitted? **Yes / No** If "YES", how long? _____
31. Name of Hospital? _____
32. What treatment was given? (Circle all that apply) **None / X-rays / Pain medication / Stitches / Muscle Relaxants / Bandaged / Neck Collar / Physical Therapy / Instructed Regarding Concussion / Instructed Regarding Sprains & Strains / Instructed to Call Physician / Other** _____
33. What doctor(s) have you seen as a result of this injury? _____
34. Do you have difficulty in excessive: Standing / Walking / Riding / Biking / Twisting

35. Do you have difficulty in excessive lifting: Light / Moderate / Heavy / Repetitive

36. Since this accident, how would you rate your health? Excellent / Good / Average / Fair / Poor

37. Circle the appropriate any of the symptoms that appeared as a result of your injury:

Headache Neck Pain Mid Back Pain Low Back Pain Shoulder Pain L/R
Elbow Pain L/R Wrist/Hand Pain L/R Hip Pain L/R Knee Pain L/R Ankle/Foot L/R
Jaw Pain L/R Numbness of _____ Tingling of _____ Other _____

38. Previous interventions, treatments, medications, surgery or care you've sought for your accident:

39. Since this motor vehicle accident, have you experienced any of the following?:

- 1) Visual Disturbance: Yes/No Please explain _____
- 2) Dizziness: Yes/No How often _____
- 3) Anxiety: Yes/No How often _____
- 4) Depression: Yes/No How often _____
- 5) Difficulty sleeping: Yes/No How often _____

40. Past Health History:

A. Previous illnesses you've had in your life: _____

B. Previous Injury or Trauma: _____

C. Surgeries: _____

D. Medications: _____

41. Family Health History: Please list any associated health problems of relatives _____

42. Social and Occupational History:

Job Description: _____ Work Hours _____

Recreational Activities: _____

Lifestyle (hobbies, level of exercise, alcohol, tobacco use, diet): _____

Patient Signature _____ Date _____