MOTOR VEHICLE ACCIDENT QUESTIONNAIRE

Name: _____Date of Accident: _____

Were you the driver or the passenger? Driver☐ Passenger ☐

If passenger, what seat were you in? Front _____ Back _____

Were you wearing a seat belt? Yes ☐ No ☐ If yes; Lap Type ☐ Shoulder Strap ☐

During impact, what direction were you looking in? Straight ahead ☐ To the side ☐

Were you aware that you were going to be hit? _____

What was the direction of impact? From Front ☐ Side impact ☐ From behind ☐

Was there more than one collision? _____

Briefly describe the accident: _____

_____

_____

_____

Was there a headrest on the seat that you were seated in? Yes ☐ No ☐

Did any part of your body impact with the car interior? Ex: windshield, dash, steering wheelé If yes, please explain: _____

_____

What type of vehicle(s) were involved? Make of yours:_____ Make of Other:_____

What were your immediate symptoms, minutes following the accident?

_____

What were your symptoms within one week of the accident?

_____

Were you knocked unconscious? Yes ☐ No ☐, Dizzy / Dazed? Yes ☐ No ☐

What form of care did you require / receive following the accident? Ambulance, Hospital visit, x-rays?

Immediate: _____

Week following: _____

Any previous motor vehicle accidents or trauma in the past? _____

Are you taking any medication due to the accident? Now: _____ Past: _____

Prior Chiropractic care before the accident? No ☐, Yes ☐ How often?_____

How do you feel presently, compared to a few days following the accident?

Same ☐, Better ☐, %better? _____ Worse ☐ %worse? _____

What are you unable to do presently, that you were able to do before the accident?

_____

Have you missed any time at work due to the accident? If yes, Please specify dates:

_____