

TriState Functional Wellness
Motor Vehicle Accident Questionnaire

Patient Name: _____ Date: _____

Date of Accident: _____ Time: _____ Place: _____

Pt. Auto Insurance Company: _____

Claims Agent Name: _____

Claims Agent Phone #: _____ Claim #: _____

Intersecting with _____

Please describe, to the best of your knowledge, what happened during this accident?

Police Investigation by: (check one or more - fill in city or county name)

_____ State Patrol _____ City Police
_____ County Sheriff _____ Other
_____ No Investigation

Road conditions at time of accident: _____ wet _____ dry _____ icy

_____ Other-please describe _____

How many passengers were in the vehicle (including yourself)? _____

Where were you seated in the vehicle? _____

Were you wearing a seat belt? _____ yes _____ no

If so, what type? _____ Lap belt only _____ shoulder and lap belt

How far is the top of the headrest from the top of your head?

approximately _____ inches above approximately _____ inches below

Was your vehicle equipped with an air bag? _____ yes _____ no

If yes, did the air bag deploy? _____ yes _____ no

Were you aware of the approaching collision prior to impact? _____ yes _____ no

Did the impact catch you by surprise? _____ yes _____ no

Did you lose consciousness (blackout) upon impact? _____ yes _____ no

If yes, for how long do you estimate _____

Your vehicle was struck from _____ behind _____ front _____ left side _____ right side

Was your car stopped at the time impact? _____ yes _____ no

If yes, was the driver's foot on the brake? _____ yes _____ no

If the foot was on the brake, was it pressing down
_____ slightly _____ moderately _____ strongly

If no, please estimate the speed of the vehicle you were in: _____ MPH

Please check one of the following if the vehicle that you were in was moving at time of impact.

- _____ Vehicle was speeding up.
- _____ Vehicle was slowing down.
- _____ Vehicle was traveling at a steady speed.

What type of car were you in? _____ Year _____ Make _____ Model

What type of car impacted with your vehicle? _____

Was the other vehicle moving at the time of the collision? _____ yes _____ no

Please check one of the following if the other vehicle was moving at time of impact.

- _____ Vehicle was speeding up.
- _____ Vehicle was slowing down.
- _____ Vehicle was travelling at a steady speed.

What else did your car hit after the initial impact with the other vehicle?

Which of the following car parts were broken during the accident?

- _____ windshield _____ right/left side window _____ steering wheel
- _____ your car seat other _____

How much was your vehicle pushed forward from the impact?

- _____ more than one car length _____ one car length
- _____ one-half car length _____ less than one-half car length
- _____ not at all

What bruises or cuts did you sustain from this accident? _____

On what part of the vehicle did the following body parts hit?

| Body Part | Part of the Vehicle | Body Part | Part of the Vehicle |
|---------------------|---------------------|----------------|---------------------|
| Head | | Right/left hip | |
| Chest | | Right/left leg | |
| Right/left shoulder | | Other: | |
| Right/left arm | | | |

What position was your head facing upon impact? _____

What parts of your body hurt?

When did your pain begin?

Which symptoms listed below did you experience following the impact?

_____ dizziness _____ blurred vision _____ numbness
 _____ tingling _____ ringing in the ears

OTHER COMMENTS:

 Patient Signature (or parent/guardian)

 Date