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