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MOTOR VEHICLE COLLISION QUESTIONNAIRE

Please answer all questions completely:

1: Where did the collision occur? City / Town: _____ State: _____

2: Date of collision: _____ Time: _____ AM PM

3: Were you the: ____ driver ____passenger ____pedestrian

4: If passenger, were you in the _____front seat ____right rear seat ____left rear seat

5: What type of vehicle were you in? _____

6: What type was the other vehicle? _____

7: Did your vehicle strike the other vehicle? ____yes ____no

8: Was your car struck by the other vehicle? ____yes ____no

9: What direction was your vehicle going? _____

10: What direction was the other vehicle going? _____

11: Was the impact from: ____the front ____the rear ____the left side ____the right side

12: What was the approximate speed at the time of the impact?:

Your vehicle _____ mph? Other vehicle _____ mph?

13: What was the weather at the time of the collision? ____dry ____wet ____icy

14: Was your vehicle in: ____park ____neutral ____in gear ____moving ____stopped

15: Were your brakes being applied? ____yes ____no

16: Was your vehicle shoved: ____forward ____backward ____sideways

17: Were you shoved: ____forward ____whipped backward

18: Did your seat have a headrest? ____yes ____no

19: If yes, what was the headrest position ____low ____mid-position ____high

20: Did your head ride up over the headrest? ____yes ____no

21: Did your hat / glasses end up in the back seat or rear window? ____yes ____no

22 Did any part of your body hit the interior of the vehicle? ____yes ____no

23: Did any part of your body hit the:

____seatbelt restraints ____steering wheel ____dashboard ___windshield

____side door ___side window other _____

24: Which part of your body hit? ____chest ____head ____chin ____face ____R L knee

____R L shoulder ____R L hand ____other _____

25: Were you holding on to the steering wheel? ____yes ____no

26: Did you brace your arms against the dash? ____yes ____no

27: Did you brace your legs against the floorboard? ____yes ____no

28: Was your ankle turned? ____yes ____no

29: Did the vehicle go into a spin or roll as a result of the impact? ____yes ____no

If yes, explain: _____

30: How much damage was there to the outside of the vehicle? ____none ____some ____a lot

31: How much damage was there to the inside of the vehicle? ____none ____some ____a lot

32: At the point of impact, where did you experience pain? Be specific:

_____

33: Immediately after the accident were you: ____conscious ____dazed ____unconscious

34: If you lost consciousness, for how long? _____

35: Were you wearing a seat belt? ____yes ____no

36: Did the belt have a shoulder harness? ____yes ____no

If yes, did it contribute to the pain you are experiencing? ____yes ____no

37: At the time of impact were you: ____looking straight ahead ____looking to the right

____looking to the left ____looking down ____looking up

38: Did the air bag deploy as a result of the impact? ____yes ____no

39: Were you braced for the impact? ____yes ____no

40: Were you surprised by the impact? ____yes ____no

41: Did you go to the hospital? ____yes ____no

Name of hospital: _____

42: If yes, when? ____right after the accident ____next day ____other _____

43 If yes, how did you get there? ____ambulance other: _____

44: If by ambulance, did the ambulance attendants place you in a:

____neck brace ____back brace other _____

45: Were any medication or medical supplies given? _____

46: Did you have X-rays, CAT scans or other tests taken at the hospital? ____yes ____no

47: Have you had any similar problems before? ____yes ____no

If yes, explain: _____

48: Are you diabetic? ____yes ____no

49: Do you have high blood pressure? ____yes ____no

50: Do you have low blood pressure? ____yes ____no

51: Do you have arthritis or degenerative joint disease? ____yes ____no

52: What type of work do you do? _____

53: What are your job requirements? _____

54: Have you lost any days of work from this injury? ____yes ____no

If yes, give dates: _____

55. Was anyone else in the vehicle with you? _____

Patient Name: _____ Date: _____

Doctor Signature: _____Date: _____

Name: _____ Date: _____

Please describe in your own words what you can and cannot do as a result of this accident.

1. Do you have physical or psychological limitations because of physical injury or pain? Describe in detail how so:

2. Do you experience limitations with inside or outside housework because of physical injury or pain? Describe in detail how so:

3. Do you experience limitations with your job duties because of physical injury or pain? Describe in detail how so:

4. Are you unable to do enjoy your usual social / family activities because of physical injury or pain? Describe in detail how so:

5. Do you experience limitations with educational classes or homework because of physical injury or pain? Describe in detail how so:

6. Do you experience limitations with your usual sex life because of physical injury or pain?

The Rivermead Post Concussion Symptoms Questionnaire

After a head injury or accident some people experience symptoms which can cause worry or nuisance. We would like to know if you now suffer any of the symptoms given below. As many of these symptoms occur normally, we would like you to *compare yourself now with before the accident.* For each one please circle the number closest to your answer.

0=Not experienced at all
1=no more of a problem now than before the accident
2=a mild problem now
3=a moderate problem now
4=a severe problem now

Compared with before the accident, do you now (i.e. over the last week) suffer from:

Headaches	0	1	2	3	4
Feelings of dizziness	0	1	2	3	4
Nausea and/or vomiting	0	1	2	3	4
Noise sensitivity, or easily upset by loud noise	0	1	2	3	4
Sleep disturbance	0	1	2	3	4
Fatigue, tiring more easily	0	1	2	3	4
Being irritable, easily angered	0	1	2	3	4
Feeling depressed or tearful	0	1	2	3	4
Feeling frustrated or impatient	0	1	2	3	4
Forgetfulness, poor memory	0	1	2	3	4
Poor Concentration	0	1	2	3	4
Taking longer to think	0	1	2	3	4
Blurred Vision	0	1	2	3	4
Light sensitivity, or easily upset or irritated by bright light	0	1	2	3	4
Double Vision	0	1	2	3	4
Restlessness	0	1	2	3	4

Are you experiencing any other difficulties? Some other symptoms of Post concussion syndrome include the following: Reading problems, writing problems (writing the wrong letter first), typing problems, inability to remember ATM or other numbers, attention impairment, personality changes, intolerance to heat, intolerance to cold, intolerance to alcohol, and loss of sex drive/libido. Please specify any of these additional problems you experience, and rate as above:

1_____	0	1	2	3	4
2._____	0	1	2	3	4
3._____	0	1	2	3	4
4._____	0	1	2	3	4

Full Name_____Signature_____Date_____