MOTOR VEHICLE COLLISION CONFIDENTIAL HEALTH QUESTIONNAIRE

NAME OF PATIENT_____

Date of Collision: _____

Patient's Position in Vehicle (check one):

- ☐ Driver
- ☐ Front Occupant
- ☐ Left Rear Occupant
- ☐ Middle Rear Occupant
- ☐ Right Rear Occupant

Patient's Seat Restraint (check one):

- ☐ Unrestrained Lap Belt ☐
- ☐ Shoulder Harness
- ☐ LapBelt and Shoulder Harness

What Type of Vehicle were you in?(check one)

☐ Compact	Mid-size ☐
☐ SUV	Van ☐
☐ Mini Van	Pickup ☐
☐ Large Truck	Tractor Trailer ☐
☐ Motorcycle	Bicycle ☐

What Type(s) of other Vehicle (s) were involved?

☐ Compact	Mid-size ☐
☐ SUV	Van ☐
☐ Mini Van	Pickup ☐
☐ Large Truck	Tractor Trailer ☐
☐ Motorcycle	Bicycle ☐

Was your vehicle ☐ **STRUCK** or did your vehicle ☐ **STRIKE ANOTHER**? (check one)

Struck Where?

☐ Back End	Left Back End ☐
☐ R Back End	Front End ☐
☐ L Front End	R Front End ☐
☐ Driver's side body	
☐ Passenger's side body	

What was your vehicle doing at the time of impact

☐ Stopped at Intersection	Stopped in Traffic ☐
☐ Slowing Down	Accelerating ☐
☐ Making a Left turn	Making a Right turn ☐
☐ Traveling in Traffic	Attempting to Change Lanes ☐

Was a Secondary Impact Reported? ☐ Y/N ☐

If so what caused the impact?

☐ A Vehicle Stopped in Front	☐ A Moving Vehicle in Front
☐ A Moving Vehicle	☐ A guardrail
☐ A Sign Post	☐ A Tree
☐ A Pedestrian	☐ A Pedestrian on a Bike
☐ Roadside Debris	

Estimated Speed of Initial Impact _____ Equiped with Airbags? ☐ Y/N ☐

Airbags Deployed? _____ Seat Back Failure Reported?_____

Damage to Vehicle: ☐ Minimal Damage ☐ Moderate Damage ☐ Severe Damage ☐ Totaled

Road Conitions: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Visability: ☐ Dry ☐ Wet ☐ Icy ☐ Snow Covered

Were you aware of the Impending Collision? ☐ Y/N ☐
Was Loss of Conciousness Reported? ☐ Y/N ☐

For how long? _____ Was Bodily Impact Reported? ☐ Y/N ☐

Bodily Impact Area(s) _____

Position of Head Rest? (check one) ☐ Even w/Head ☐ Even w/Bottom of Head ☐ Absent

What was your position at the time of the collision?

☐ Relaxed ☐ Tense ☐ Straining Foward ☐ Gripping Wheel

Position of Head and Neck at Impact?

☐ Facing Foward ☐ Rotated Left ☐ Rotated Down ☐ Facing Up ☐ Facing Down

Where did you go after the collision? ☐ Home ☐ Hospital ER ☐ Doctor's Office ☐ Work

Were you Hospitalized? ☐ Y/N ☐
Name of Hospital: _____

Treatment Provided by The Hospital:

- ☐ Medication for Pain
- ☐ X-Rays
- ☐ Ice to Relieve Swelling
- ☐ Medication for Pain and Spasm
- ☐ CT Scan
- ☐ Emergency LifeSaving Procedures
- ☐ Medication for Spasm
- ☐ MRI
- ☐ Stitches

Other _____

Since the time of the collision, has your condition

☐ Not Changed ☐ Slightly Improved ☐ Slightly Worsened ☐ Significantly Worsened

What is your most important complaint (C.C.)?

_____

_____

When did this complaint (C.C.) first begin?

_____

_____

How did the C.C. begin:

☐ Gradually/slowly
- ☐ Occasionally present
- ☐ Constantly present

☐ Suddenly/quickly
- ☐ Occasionally present
- ☐ Constantly present

Pain level:

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
0 1 2 3 4 5 6 7 8 9 10

Gets worse with:

☐ Standing
☐ Bending
☐ Lifting
☐ Sneezing
☐ Coughing
☐ Twisting
☐ Lying Down
☐ Nothing affects it
☐ Temperature

☐ Other activities and/or movements:

_____

_____

Gets Better with:

☐ Rest
☐ Medication
☐ Walking
☐ Stretching
☐ Lying down
☐ Excersise
☐ Nothing affects it
☐ Other activities and/or movements:

_____

_____

Is the C.C. getting:

☐ Worse
☐ Better
☐ Staying the same
☐ Do you have any other comments?

_____

_____

Pain description:

☐ Achy
☐ Tingly
☐ Throbbing
☐ Spasm
☐ Numb
☐ Burning
☐ Other:

_____

_____

_____

Have you ever had any prior complaints to the affected region? ☐ Y/N ☐

_____

If yes, have you resolved the complaint so that it is non-contributory ? ☐ Y/N ☐

_____

Did the current complaint exist already and has become worse as a result of the injury in question?

_____

Past Medical History

- ☐ Hypertension
- ☐ Heart Disease
- ☐ Stroke
- ☐ Diabetes
- ☐ Thyroid Disorder
- ☐ Cancer
- ☐ GERD
- ☐ Ulcer
- ☐ RA
- ☐ OA
- ☐ Hepatitis
- ☐ Depression
- ☐ Anxiety
- ☐ CORD
- ☐ TB
- ☐ Renel Disease
- ☐ Hepatic Desease
- ☐ Obesity
- ☐ Seizures
- ☐ High Cholesteral
- ☐ Contagious illness(es)
- ☐ Other:_____
  _____

Past Surgical History:

- ☐ Gastric Bypass
- ☐ Heart Bypass
- ☐ Hernia Repair (inguinal)
- ☐ Hernia Repair(umbilical)
- ☐ Appendectomy
- ☐ Gallbladder Removal
- ☐ Cateract Surgery
- ☐ Cesarean
- ☐ Hysterectomy
- ☐ Mastectomy
- ☐ Low Back Surgery
- ☐ Neck Surgery
- ☐ Tonsillectomy
- ☐ Other
  _____
  _____

Medical Alert:

- ☐ Addicted to Alchohol
- ☐ Diabetic
- ☐ Addicted to Drugs
- ☐ HIV
- ☐ Pacemaker
- ☐ Pregnant
- ☐ Seizures
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Other
  _____
  _____

Habits

Alcohol:

- ☐ Heavy
- ☐ Social
- ☐ None
- ☐ Former Alcoholic

Smoking/Tobacco:

- ☐ Heavy Smoker
- ☐ Light Smoker
- ☐ Chew Tobacco
- ☐ None
- ☐ Former Smoker

Drugs:

- ☐ Recreational Use
- ☐ None

What other Medical Providers have you seen since the accident/onset of complaint?

NAME	*CITY*	*DATE OF FIRST VISIT*	*REASON*	*UNDER CARE STILL?*
				☐ *Y/N* ☐
				☐ *Y/N* ☐
				☐ *Y/N* ☐
				☐ *Y/N* ☐