MOTOR VEHICLE COLLISION DESCRIPTION

Collision Description
Check all that apply to you:

❑ Single-car crash	❑ Two-vehicle crash	❑ More than three vehicles
❑ Rear-end crash	❑ Side crash	❑ Rollover
❑ Head-on crash	❑ Hit guardrail/tree	❑ Ran off road

You were the

❑ Driver	❑ Front passenger	❑ Rear passenger

Describe the vehicle you were in
Model year and make:

❑ Subcompact car	❑ Compact car	❑ Mid-sized car
❑ Full-sized car	❑ Pickup truck	❑ Larger than 1 ton vehicle

Describe the other vehicle
Model year and make:

❑ Subcompact car	❑ Compact car	❑ Mid-sized car
❑ Full-sized car	❑ Pickup truck	❑ Larger than 1 ton vehicle

Estimated crash speeds
Estimate how fast your vehicle was moving at time of crash. _____ km
Estimate how fast the other vehicle was moving at time of crash. _____ km

At the time of impact your vehicle was

❑ Slowing down	❑ Stopped	❑ Gaining speed	❑ Moving at steady speed

At the time of impact the other vehicle was

❑ Slowing down	❑ Stopped	❑ Gaining speed	❑ Moving at steady speed

During and after the crash, your vehicle

❑ Kept going straight, not hitting anything	❑ Spun around, not hitting anything
❑ Kept going straight, hitting car in front	❑ Spun around, hitting another car
❑ Was hit by another vehicle	❑ Spun around, hitting object other than car

Describe yourself during the crash
Check only the areas that apply to you:
❑ You were unaware of the impending collision.
❑ You were aware of the impending crash and relaxed before the collision.
❑ You were aware of the impending crash and braced yourself.
❑ Your body, torso, and head were facing straight ahead.
❑ You had your head, and/or torso turned at the time of collision:
    ❑ Turned to left ❑ Turned to right
❑ You were intoxicated (alcohol) at the time of crash.
❑ You were wearing a seat belt.
    If yes, does you seat belt have a shoulder harness? ❑ Yes ❑ No
❑ You were holding onto the steering wheel at the time of impact.

Indicate if your body hit something or was hit by any of the following

Please draw lines and match the left side to the right side.

Head	Windshield
Face	Steering wheel
Shoulder	Side door
Neck	Dashboard
Chest	Car frame
Hip	Another occupant
Knee	Seat
Foot	Seat belt

Check if any of the following vehicle parts broke, bent, or were damaged in your car

❑ Windshield	❑ Seat frame	❑ Knee bolster
❑ Steering wheel	❑ Side/rear window	❑ Other _____
❑ Dash	❑ Mirror	❑ Other _____

Rear-end collisions only

Answer this section only if you were hit from the rear.

Does your vehicle have

❑ Movable head restraints

❑ Fixed, nonmovable head restraints

❑ No head restraints

Please indicate how your head restraint was positioned at the time of crash.*

❑ At the top of the back of your head

❑ Midway height of the back of your head

❑ Lower height of the back of your head

❑ Located at the level of your neck

❑ Located at the level of your shoulder blades (upper back) below neck

*Estimate the distance between the back of your head and the front of the head restraint. _____cm

All types of collisions

Answer this section regardless of the type of crash, indicating those relevant to your case.

Yes	No	
❑	❑	Did any of the front or side structures, such as the side door, dashboard, or floorboard of your car, dent inward during the crash?
❑	❑	Did the side door touch your body during the crash?
❑	❑	Was your hand(s) on the steering wheel or dash during the crash?
❑	❑	Did your body slide under the seat belt?
❑	❑	Was the door(s) of your vehicle damaged to the point where you could not open the door?

Emergency department

Yes	No	
❑	❑	Did you go to the emergency department after the accident? What is the name of the emergency department? _____ When did you go (date and time)? _____
❑	❑	Did you go to the emergency department in an ambulance?
❑	❑	Did you or another person drive you to the emergency department?

❑ ❑ Were you hospitalized overnight?
❑ ❑ Did the emergency department doctor take X-rays? Check what was taken:
- ❑ Skull
- ❑ Neck
- ❑ Low back
- ❑ Arm or leg

❑ ❑ Did the emergency department doctor give you pain medications?
❑ ❑ Did the emergency department doctor give you muscle relaxants?
❑ ❑ Did you have any cuts or lacerations?
❑ ❑ Did you require any stitching for cuts?
❑ ❑ Were you given a neck collar or back brace to wear?

When did you first notice any pain after injury?
❑ Immediately ❑ _____ Hours after injury ❑ _____ Days after injury

If you did not see a doctor for the first time within the first week, indicate why
Check all that apply

❑ No pain was noticed
❑ No transportation
❑ I thought pain would go away
❑ I self-treated with over-the-counter drugs
❑ No appointment schedule available
❑ Work/home schedule conflicts
❑ I had no insurance or money
❑ I took hot showers, used ice, heat

Have you been unable to work since injury?
❑ **Yes** ❑ **No** If yes, you were off work ❑ partially or ❑ completely
Please list dates off work: _____ to _____

PATIENT INSTRUCTIONS: It is important for this section to be filled out in detail. CHECK if you have had any single or multiple symptom(s) listed below. Leave row blank if the symptom listed does not apply to you.

Symptom List	Felt Right After Injury	Felt 24-48 Hours Later	Have Symptoms Now	Had Similar Symptoms 1-3 Months Before This Injury
Headache				
Dizziness				
Tinnitus (ear ringing)				
Blurry vision				
Memory problems				
Poor concentration				
Irritability				
Balance problems				
Loss of coordination				
Sensitivity to sound				
Sensitivity to light				
Fatigue				
Anxiety				
Pain/difficulty swallowing				
Jaw pain				
Neck pain/soreness				
Neck stiffness				
Shoulder pain/stiffness				
Arm pain/tingling/numbness				
Wrist/hand/finger pain/numbness				
Weakness in arms/legs				
Upper/mid back pain				
Chest wall pain (rib)				
Low back pain/soreness				
Hip pain				
Leg pain				
Leg numbness/tingling				
Pain shoots down legs				
Knee pain				
Ankle/foot pain				
Other				

LIST ALL DOCTORS, TESTS, AND TREATMENTS SINCE INJURY

Start with the first doctor/office/hospital you saw after your injury and check all that apply:

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①

Name hospital/doctor/therapist/center: _____

Address: _____ Date: _____

Indicate what was done:

- ❑ Exam-consultation
- ❑ X-ray of neck
- ❑ X-ray of low back
- ❑ Other X-rays
- ❑ MRI/CT scan
- ❑ Other diagnostic test
- ❑ Rehabilitation
- ❑ Physical therapy
- ❑ Exercises recommended
- ❑ Medications prescribed
- ❑ Neck collar
- ❑ Spinal manipulation/adjustments
- ❑ Muscle massage/myotherapy
- ❑ Low back brace
- ❑ Heat packs
- ❑ Cold/ice packs
- ❑ Ultrasound
- ❑ Other

Indicate if treatment: ❑ Made condition worse ❑ Did not help ❑ Helped

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②

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MEDICATIONS: Currently taking.

Medications	Reason for Medication	How long have you been taking them?

MEDICAL HISTORY: Have you ever been diagnosed with any of the following? (✓)

Conditions	YES	NO	Past	Comments
Cancer				
Diabetes				
Heart conditions				
High blood pressure				
Thyroid disorders				
Lung conditions				
Rheumatoid arthritis				
Ankylosing spondylitis				
Other arthritis				
Epilepsy				
Fibromyalgia				
HIV				
Asthma				
Anemia				
Osteoporosis				
Are you pregnant?				
Are you amenorrheic?				

Have you had any other injuries or trauma? _____

- Car Accidents? YES NO
- Sports Injuries? (please describe) _____
- Broken Bones? (please describe) _____

Have you had any recent surgery? (please describe) _____

_____

Have you had major surgery in the past? (please describe) _____

_____

Do you have: Allergies _____ Metal Implants _____

Pacemaker_____ IUD_____