EMPIRE REHAB

MOTOR VEHICLE COLLISON QUESTIONNAIRE

Date Of Accident

Did the pain start instantly	YES	NO	If no, when did it start?
Did you lose conscious	YES	NO	
Did you go to the hospital	YES	NO	If YES, name of hospital? Date?
X Ray, MRI, CT testing	YES	NO	
Any prescribed medications?	YES	NO	If YES, what and who prescribed them?

COLLISION DESCRIPTION

Single vehicle crash	Off center impact	Three or more vehicles
Rear end crash	Side crash	Rollover
Head on crash	Hit guard rail, tree or object	Ran off the road

TYPES OF VEHICLES INVOLVED

Year, make & model of the vehicle you were in:

Year, make & model of the other vehicle(s):

BODY DESCRIPTION

Were you the driver?	YES	NO	If no, where were you sitting?
Were you wearing a seatbelt?	YES	NO	Did it bruise you?
Your body hit inside the car?	YES	NO	Which body part?
Did the airbags deploy?	YES	NO	
Did the seat break?	YES	NO	
Did your head hit the headrest?	YES	NO	
Both hands on steering wheel?	YES	NO	
Was your foot on the break?	YES	NO	

How much damage was done to your car? ((Monetary amount)

How much damage was done to other car? ((Monetary amount)

Did the driver of your car or you get a cited ticket? YES NO

Was your car able to drive away? YES NO Was the other car able to drive away? YES NO

Did the police issue a report? YES NO

Did the driver of the other car get cited for a ticket? YES NO

Patient/Guardian Signature Date