Theriault Chiropractic and Injury Clinic
1846 S. Tamiami Trail Suite 1
Venice, FL 34293 (P) 941-497-7005 (F) 941-493-6905

MOTOR VEHICLE COLLISION QUESTIONNAIRE

Please answer all questions completely:

1. Your name and address:

_____

_____

2. Phone Number: _____

3. Please describe the collision in your own words:

_____

_____

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

5. Date of collision: _____ Time: _____ AM PM

6. Were you the: □ driver □ passenger □ pedestrian

7. If passenger, were you in the □ front seat □ right rear seat □ left rear seat

8. What type of vehicle were you in? _____

9. What type was the other vehicle? _____

10. Did your vehicle strike the other vehicle? □ yes □ no

11. Was your car struck by the other vehicle? □ yes □ no

12. What direction was your vehicle going? _____

13. What direction was the other vehicle going? _____

14. Was the impact from: □ the front □ the rear □ the left side □ the right side

15. What was the approximate speed at the time of the impact?

Your vehicle _____ mph Other vehicle _____ mph

16. What was the weather at the time of the collision? □ dry □ wet □ icy

17. Was your vehicle in: □ park □ neutral □ in gear □moving □stopped

18. Were your brakes being applied? □ yes □ no

19. Was your vehicle shoved: □ forward □ backward □ sideways

20. Were you shoved: □ forward □ whipped backward

21. Did your seat have a head restraint (headrest?) □ yes □ no

22. If yes, what was the position □ low □ mid-position □ high

23. Did your head ride over the headrest? □ yes □no

24. Did your hat/glasses end up in the back seat or rear window? □ yes □ no

25. Did any other part of your body hit the interior of the vehicle? □ yes □ no

26. If yes, please specify: □ seatbelt restraints □ steering wheel □ dashboard □ windshield □ side door □ side window □ other _____

27. Which part of your body? □ chest □ head □ chin □ face □ R L knee □ R L shoulder □ R L hand □ other _____

28. Were you holding on to the steering wheel? □ yes □ no

29. Did you brace your arms against the dash? □ yes □ no

30. Did you brace your legs against the floorboard? □ yes □ no

31. Was your ankle turned? □ yes □ no

32. Did the vehicle go into a spin or roll as a result of the impact? □ yes □ no

Theriault Chiropractic and Injury Clinic
1846 S. Tamiami Trail Suite 1
Venice, FL 34293 (P) 941-497-7005 (F) 941-493-6905

33. If yes, explain: _____
34. How much damage was there to the outside of the vehicle? □ none □ some □ a lot
35. How much damage was there to the inside of the vehicle? □ none □ some □ a lot
36. At the point of impact, where did you experience pain? Be specific:
_____
37. Immediately after the accident were you: □ conscious □ dazed □ unconscious
38. If you lost consciousness, how long? _____
39. Were you wearing a seat belt? □ yes □ no
40. Did the belt have a shoulder harness? □ yes □ no
41. If yes, did it contribute to the pain you are experiencing? □ yes □ no
42. At the time of impact were you: □ looking straight ahead □ looking to the right □ looking to the left □ looking down □looking up
43. Did the seat break as a result of the impact? □ yes □ no
44. Were you braced for the impact? □ yes □ no
45. Were you surprised by the impact? □ yes □ no
46. Did you go to the hospital? □ yes □ no
47. If yes, when? □ right after the accident □ next day □ other _____
48. If yes, how did you get there? □ ambulance other: _____
49. If by ambulance, did the ambulance attendants place you in a: □ neck brace □ back brace □ other _____
50. Any medication or medical supplies given? _____
51. Did you have x-rays taken at the hospital? □ yes □ no

If you went to the hospital, please answer the following:
Name of hospital _____
Treatment Received _____

52. Have you had any similar problems before? □ yes □ no
53. If yes, explain: _____
54. Are you diabetic? □ yes □ no
55. Do you have high blood pressure? □ yes □ no
56. Do you have low blood pressure? □ yes □ no
57. Do you have arthritis or degenerative joint disease? □ yes □ no
58. What type of work do you do? _____
59. What are your job requirements? _____
60. Have you lost any days of work from this injury? □ yes □ no
61. If yes, give dates: _____

Patient Signature _____ Date _____
Print Name _____