Motor Vehicle Collision Form

Patients Name:_____ **Date:** ____ / ____ /____

1) Please choose the date of the MVC: _____ / _____ /_____

2) Please the time of the MVC: _____ : _____ am / pm

3) Please enter the number of vehicles involved in the MVC:

_____1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____9

4) In dollars, please enter the estimated damage to your vehicle $_____

5) What road were you on? _____

6) What direction were you travelling in?

NW	N	NE	W	E	SW	S	SE

7) What city & state were you travelling in? _____

8) Please choose the primary type of impact:

vehicle was rear ended	vehicle hit another vehicle from behind	vehicle was hit on the passenger's side

9) What did the vehicle do immediately after the accident?

hit a guardrail	hit a tree	rolled over	was run off the road

Other: _____

10) Where were you sitting in this vehicle?

driver	rear left passenger	rear passenger
front passenger	rear right passenger	

Other: _____

11) Did you know the accident was coming?

was unaware of the impending collision	was aware the impending collision and she braced herself
was aware of the collision and relaxed	

Other: _____

12) What is the type of vehicle you were in?

subcompact car	compact car	mid-size car	full-sized car	truck
SUV	minivan	van	larger than one ton vehicle	

Other: _____

13) At the time of impact, your vehicle was:

slowing down	gaining speed	stopped	moving at a steady speed

Other: _____

14) At impact the other vehicle involved was:

slowing down	gaining speed	stopped	moving at a steady speed

Other: _____

15) During and after the crash, what happened to your vehicle?

kept going straight	kept going straight hitting a car in front of her	was hit by another vehicle
spun around	spun around and hit a stationary object	

Other: _____

16) Did you lose consciousness during the accident?

lost consciousness during the accident	remained conscious throughout entire accident

Other: _____

17) How was your head positioned during the accident?

head facing forward	head turned to the left	head turned to the right	head facing upward	head facing downward
head facing to the right and upward	head facing to the right and downward	head facing left and upward	head facing left and downward	

Other: _____

18) How was your torso positioned during the accident?

torso positioned forward	torso positioned to the left	torso positioned to the right	torso extended	torso flexed
torso flexed with right rotation	torso extended with right rotation	torso flexed with left rotation	torso extended with left rotation	

Other: _____

19) How were your hands positioned during the accident?

left hand on the steering wheel	right hand on the steering wheel	both hands on the steering wheel	left hand on dashboard	right hand on dashboard
both hands on dashboard	hand on the seat in front	hands resting along side	hands on ceiling of the car	

Other: _____

20) Did your head hit any of the following?

windshield	steering wheel	side door	dashboard	ceiling
carframe	another passenger	seat	side window	

Other: _____

21) Did your face hit any of the following?

windshield	steering wheel	side door	dashboard	ceiling
carframe	another passenger	seat	side window	

Other: _____

22) Did your shoulders hit any of the following?

windshield	steering wheel	side door	dashboard	ceiling
carframe	another passenger	seat	side window	

Other: _____

23) Did your neck hit any of the following?

windshield	steering wheel	side door	dashboard	ceiling
carframe	another passenger	seat	side window	

Other: _____

24) Did your chest hit any of the following?

windshield	steering wheel	side door	dashboard	ceiling
carframe	another passenger	seat	side window	

Other: _____

25) Did your hips hit any of the following?

windshield	steering wheel	side door	dashboard	ceiling
carframe	another passenger	seat	side window	

Other: _____

26) Did your knees hit any of the following?

windshield	steering wheel	side door	dashboard	ceiling
carframe	another passenger	seat	side window	

Other: _____

27) Did your feet hit any of the following?

windshield	steering wheel	side door	dashboard	ceiling
carframe	another passenger	seat	side window	

Other: _____

28) What kind of headrests were in your vehicle?

movable fixed head restraints	fixed, non movable head restraints	no head restraints

Other: _____

29) Where was your headrest positioned on your head?

at the top of the back of head	at the middle height of the bad of head	at the lower portion of the back of head
at the level of the back of neck	at the level of the shoulder blades	

Other: _____

30) Did you have your seatbelt on?

was wearing a shoulder strap seat belt	was wearing a lap belt seat belt	was in a baby car seat
was not wearing her seatbelt	cannot remember is she had a seat belt on	was in a booster seat

31) Did you slide out of your seatbelt?

slid out of seatbelt	remained in seatbelt	partially slid out of seatbelt

Other: _____

32) What was damaged in your vehicle?

windshield	steering wheel	dashboard	seat frame
side window	rear window	mirror	knee bolster
rear bumper	trunk	completely totaled	front left door
front right door	back left door	back right door	none

Other: _____

33) Choose the items that dented inward during the accident?

side door	dashboard	floor board	none

Other: _____

34) Choose the doors that would not open as a result of accident?

side door	dashboard	floor board	none

Other: _____

35) How did you go to the hospital?

ambulance	helicopter	police car
drove herself	walking	N/A didn't go to hospital

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36) Please choose the locations of your problems:

headaches	jaw	neck	upper back	shoulder
arm	elbow	wrist	hand	mid back
low back	hip	legs	knee	ankle
foot				

Other: _____

37) Were you hospitalized overnight?

_____ yes _____ no _____ n/a

38) At the hospital, were you prescribed pain medication?

_____ yes _____ no _____ n/a

39) Were you prescribed muscle relaxers at the hospital?

_____ yes _____ no _____ n/a

40) Did you receive stitches for any cuts?

_____ yes _____ no _____ n/a

41) Did you receive any of the following? _____ yes _____ no _____ n/a

Cervical Collar	back brace	Cervical collar and back brace	n/a

42) Which xrays were taken at the hospital?

skull	neck	midback	lowerback	foot	arm
pelvis	hips	leg	knee	shoulder	no x-rays

Other: _____

43) Was an MRI performed?

skull	neck	midback	lowerback	foot	arm
pelvis	hips	leg	knee	shoulder	no MRI

Other: _____

44) Did you receive any special imaging?

skull	neck	midback	lowerback	foot	arm
pelvis	hips	leg	knee	shoulder	no special imaging

Other: _____

_____ _____

Signature of patient, or of Guardian authorizing care Date