pain management AT GARDEN STATE MEDICAL CENTER

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Motor Vehicle Accident Questionnaire

Name:____ **Date**: _______________________

Who accompanied patient to the appointment?___________________________________

Hand Dominance: ☐ Right ☐ Left

PRIOR ACCIDENT HISTORY:

Was there a previous accident? ☐ Yes ☐ No

If yes, what body part was injured? ☐ Right ☐ Left ☐ Bilateral

☐ Abdomen	☐ Clavicle	☐ Hand	☐ Low back	☐ Sternum
☐ Ankle	☐ Elbow	☐ Head	☐ Mid Back	☐ Upper Back
☐ Arm	☐ Face	☐ Hip	☐ Neck	☐ Wrist
☐ Calf	☐ Foot	☐ Knee	☐ Pelvis	
☐ Chest	☐ Groin	☐ Leg	☐ Shoulder	

PRIOR TREATMENT i.e. Chiropractor, physical therapy, surgery, etc.

____

____

Were injuries resolved: ☐ Yes ☐ No

If no, please explain:____

CURRENT ACCIDENT HISTORY:

Date of Accident: ______________ **Time of Accident**: ______________

Location of Accident: (Town and Road) ____________________________________

Light Condition: ☐ Daylight ☐ Dark with street lights on
☐ Dark with street lights off ☐ Dark no street lights

Road Conditions: ☐ dry ☐ wet ☐ icy ☐ snow ☐ slush
☐ mud ☐ moving water ☐ standing water ☐ windy

Where was patient sitting in the car? ☐ Driver ☐ Front passenger ☐ Rear passenger
☐ Rear Right ☐ Rear Middle ☐ Rear Left

Was patient wearing a seatbelt? ☐ Yes ☐ No

Car moving: ☐ Moving ☐ Moving in traffic ☐ Stopped

Hit or hit another vehicle: ☐ Was hit ☐ Hit another vehicle

How was patient hit: ☐ Hit head on ☐ Front driver side
☐ Front passenger side ☐ Rear left driver side ☐ Rear right passenger side
☐ Rear ended ☐ T-boned (Broad Sided)

Approximate Speed at time of Impact: MPH ______________________________

Hands on Steering Wheel: ☐ Right hand ☐ Left hand ☐ Both hands

Prepared for Impact: ☐ Yes ☐ No

Loss of consciousness: ☐ Yes ☐ No

Did the airbag deploy: ☐ Yes ☐ No

Police Notified: ☐ Yes ☐ No

Did patient go to the hospital: ☐ Yes ☐ No **Via Ambulance:** ☐ Yes ☐ No

Name of Hospital: ___________________________

Did any part of body come in contact with car? Note Right, Left or Bilateral

☐ abdomen ☐ clavicle ☐ hand ☐ ankle ☐ elbow ☐ sternum
☐ neck ☐ upper back ☐ mid back ☐ low back ☐ wrist ☐ leg
☐ arm ☐ face ☐ hip ☐ calf ☐ head ☐ foot
☐ knee ☐ shoulder ☐ Chest ☐ groin

Car Part Hit by Body Part:

☐ Airbag ☐ Passenger side head rest ☐ Rear passenger side right window
☐ Driver side door ☐ Passenger side window ☐ Rear passenger side left door
☐ Driver side head rest ☐ Rear driver side left door ☐ Rear passenger side left window
☐ Driver side window ☐ Rear driver side left window ☐ Steering Wheel
☐ Passenger side door ☐ Rear passenger side right door ☐ Windshield

Other (explain)____

Body Movement at Time of Impact: ☐ Right ☐ Left ☐ Bilateral ☐ Flexion
☐ Extension ☐ Rotation ☐ Side Bending

Body parts injured: ☐ Right ☐ Left ☐ Bilateral

☐ Abdomen ☐ Clavicle ☐ Hand ☐ Low back ☐ Sternum
☐ Ankle ☐ Elbow ☐ Head ☐ Mid Back ☐ Upper Back
☐ Arm ☐ Face ☐ Hip ☐ Neck ☐ Wrist
☐ Calf ☐ Foot ☐ Knee ☐ Pelvis ☐ Chest
☐ Groin ☐ Leg ☐ Shoulder ☐ Other (explain)________________________________

How much damage was done to automobile: ☐ Total loss ☐ Minimal Damage

Other (explain)____

Did patient seek treatment after the hospital: ☐ Yes ☐ No

Name of physician seen: ____

Specialty <name of specialty>: ____

Date of initial visit: ____

Medications prescribed: ☐ Yes ☐ No

If yes, what medications: ____

CT scan: ☐ Right ☐ Left

Type: ☐ Lumbar ☐ Cervical ☐ Other _________________________________

Contrast: ☐ With ☐ Without ☐ With and Without

Facility: __________________________________

CT Scan Date:__________________________________

MRI: ☐ Right ☐ Left

Type: ☐ Lumbar ☐ Cervical ☐ Other _________________________________

Contrast: ☐ With ☐ Without ☐ With and Without

Facility: __________________________________

MRI Date: __________________________________

X-Ray: ☐ Right ☐ Left

Type: ☐ Lumbar ☐ Cervical ☐ Other _________________________________

Facility: __________________________________

X-Ray Date: __________________________________

EMG: Facility:______________________________

Date: ______________________________

Did patient have physical therapy or chiropractic treatment? ☐ Yes ☐ No

☐ Physical therapy ☐ Chiropractor ☐ Acupuncture ☐ Massage Therapy ☐ Home exercise

Facility:__________________________________

Treatment: ☐ Electric Stimulation ☐ Exercise ☐ Hot Packs ☐ Ice

☐ Manipulation ☐ Traction ☐ Ultrasound ☐ Other____________________

How many days a week: ____________

Treatment Start Date: ______________

Currently treating for injuries? ☐ Yes ☐ No

Work Status:

Is patient currently working? ☐ Yes ☐ No

If no, last date worked due to injuries: ______________

If yes, was any work missed due to injuries: ☐ Yes how much? _________ ☐ No

Attorney information:

Attorney Name: ____

Attorney Address: ____

____

Attorney Phone: ____

Patient Name: _________________________

Patient Signature: _______________________

Date: __________