

NEW SOUTH MEDICAL

MOTOR VEHICLE COLLISION 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

