

# MOTOR VEHICLE CRASH FORM (Page 1)

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_  
 Date of injury: \_\_\_\_\_ Time of injury \_\_\_\_\_  AM  PM  
 City where crash occurred: \_\_\_\_\_ Was the street wet or dry?  Wet  Dry  
 Street (location) where crash occurred: \_\_\_\_\_  
 What is the estimated repair damage to your vehicle? \$ \_\_\_\_\_  
 Who made damage estimates on your vehicle? \_\_\_\_\_  
 Who owns the vehicle you were involved in: \_\_\_\_\_  
 Yes,  No Did the police come to the accident scene?  
 Yes,  No Did the police make a written report?  
 Yes,  No Were any photographs taken of your vehicle? If yes, who took them: \_\_\_\_\_  
 Yes,  No Did you go to the hospital? If yes, which hospital: \_\_\_\_\_  
 Did you go to the hospital by:  Ambulance  Car  Other

## DESCRIBE HOW THE CRASH HAPPENED

## COLLISION DESCRIPTION-TYPE

*Check all that apply to you. Indicate which type of car crash were you involved in:*

<input type="checkbox"/> Single-car crash	<input type="checkbox"/> Two-vehicle crash	<input type="checkbox"/> Three or more vehicles
<input type="checkbox"/> Rear-end crash	<input type="checkbox"/> Side crash	<input type="checkbox"/> Rollover
<input type="checkbox"/> Head-on crash	<input type="checkbox"/> Hit guard rail, tree, or object	<input type="checkbox"/> Ran off the road
<input type="checkbox"/> Other (Describe): _____		

## INDICATE YOUR SEATING POSITION

<input type="checkbox"/> Driver	<input type="checkbox"/> Front passenger	<input type="checkbox"/> Left rear passenger	<input type="checkbox"/> Right rear passenger
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## DESCRIBE THE VEHICLE YOU WERE IN:

Model, Make, and Year: _____		
<input type="checkbox"/> Small-sized car	<input type="checkbox"/> Mid-sized car	<input type="checkbox"/> Large-sized car
<input type="checkbox"/> Pick-up truck	<input type="checkbox"/> Van	<input type="checkbox"/> Sport Utility Vehicle (SUV)
<input type="checkbox"/> 2 Door vehicle	<input type="checkbox"/> 4 Door vehicle	<input type="checkbox"/> Large truck, bus, or semi-truck
<input type="checkbox"/> Sedan	<input type="checkbox"/> Hatchback	<input type="checkbox"/> Stationwagon
<input type="checkbox"/> Other (Describe): _____		

## DESCRIBE THE OTHER VEHICLE (If not certain, leave blank):

Model, Make, and Year: _____			<input type="checkbox"/> Unknown
<input type="checkbox"/> Small passenger car	<input type="checkbox"/> Mid-sized passenger car	<input type="checkbox"/> Van	
<input type="checkbox"/> Pick-up truck/sports utility	<input type="checkbox"/> Large-sized passenger car	<input type="checkbox"/> Large truck, bus, or semi-truck	
<input type="checkbox"/> Sport Utility Vehicle (SUV)	<input type="checkbox"/> Stationwagon	<input type="checkbox"/> Other:	

# MOTOR VEHICLE CRASH FORM (Page 2)

## AT THE TIME OF IMPACT YOUR VEHICLE WAS:

<input type="checkbox"/> Slowing down	<input type="checkbox"/> Gaining Speed	<input type="checkbox"/> Unknown speed
<input type="checkbox"/> Stopped	<input type="checkbox"/> Moving at steady speed	<input type="checkbox"/> Other:

## AT THE TIME OF IMPACT THE OTHER VEHICLE WAS:

<input type="checkbox"/> Slowing down	<input type="checkbox"/> Gaining Speed	<input type="checkbox"/> Unknown speed
<input type="checkbox"/> Stopped	<input type="checkbox"/> Moving at steady speed	<input type="checkbox"/> Other:

## DURING AND AFTER THE CRASH, YOUR VEHICLE:

<input type="checkbox"/> Kept going straight, not hitting anything	<input type="checkbox"/> Spun around, not hitting anything
<input type="checkbox"/> Kept going straight, hitting car in front	<input type="checkbox"/> Spun around, hitting another car
<input type="checkbox"/> Was hit by another vehicle	<input type="checkbox"/> Spun around, hitting object other than car

## INDICATE IF YOUR BODY HIT SOMETHING OR WAS HIT BY ANY OF THE FOLLOWING: Please draw lines from the body regions on the left side and match to the right side.

BODY REGION	OBJECT YOU HAD CONTACT WITH
Head	Windshield or side window
Face	Steering wheel
Shoulder	Side of door
Arm/hand	Dashboard
Front chest wall	Knee bolster/glove compartment
Side chest wall	Seatbelt (lap belt or shoulder harness)
Hip/abdomen	Frame of car near windows
Knee	Roof or top part of vehicle
Leg	Another occupant/animal
Foot	Other

## CHECK IF ANY OF THE FOLLOWING VEHICLE PARTS BROKE, BENT, OR WERE DAMAGED IN YOUR CAR:

<input type="checkbox"/> Windshield	<input type="checkbox"/> Seat frame	<input type="checkbox"/> Knee bolster
<input type="checkbox"/> Steering wheel	<input type="checkbox"/> Side-rear window	<input type="checkbox"/> Other
<input type="checkbox"/> Dash	<input type="checkbox"/> Mirror	<input type="checkbox"/> Other

## ALL TYPES OF COLLISIONS Indicate those relevant to your case.

YES NO

<input type="checkbox"/>	<input type="checkbox"/>	Did any of the interior front or side structures, such as the side door, dashboard, steering wheel, or floorboard of your car dent inward during the crash?
<input type="checkbox"/>	<input type="checkbox"/>	Did the side door touch your body during the crash?
<input type="checkbox"/>	<input type="checkbox"/>	Did your body slide under the seatbelt?
<input type="checkbox"/>	<input type="checkbox"/>	Was the door(s) of your vehicle damaged to point where you could not open the door?
<input type="checkbox"/>	<input type="checkbox"/>	Did an airbag deploy in your vehicle during the crash? If yes, circle (side air bag/front air bag)
<input type="checkbox"/>	<input type="checkbox"/>	Were you intoxicated (alcohol) at the time of crash?

## MOTOR VEHICLE CRASH FORM (Page 3)

### SEATBELT USAGE AND STEERING WHEEL HAND PLACEMENT:

YES NO

<input type="checkbox"/>	<input type="checkbox"/>	Were you wearing a seatbelt? If yes, does your seatbelt have a: <input type="checkbox"/> Lap and Shoulder Strap, <input type="checkbox"/> Lap belt only
<input type="checkbox"/>	<input type="checkbox"/>	Did you have any portion of your seatbelt positioned behind your chest, back or shoulder.
<input type="checkbox"/>	<input type="checkbox"/>	Were you holding onto the steering wheel (driver only) at the time of impact? If yes, Indicate where each hand was positioned ( <i>Use time clock face as your reference point</i> ) Left hand: <input type="checkbox"/> Not on wheel, <input type="checkbox"/> Yes, hand at ____ o'clock, <input type="checkbox"/> Hand elsewhere Right hand: <input type="checkbox"/> Not on wheel, <input type="checkbox"/> Yes, hand at ____ o'clock, <input type="checkbox"/> Hand elsewhere

### REAR-END COLLISIONS ONLY Answer this section only if you were hit from the rear.

#### Describe your vehicle's head restraint system:

- |  |  |
|--|--|
| <input type="checkbox"/> Movable/adjustable head restraint | <input type="checkbox"/> Fixed, non-moveable head restraint                |
| <input type="checkbox"/> No headrests in my vehicle        | <input type="checkbox"/> Bench seat in your vehicle without head restraint |

#### Please indicate how your head restraint was positioned at the time of crash (if present):

- |  |   |
|--|---|
| <input type="checkbox"/> At the top of the back of your head   | <input type="checkbox"/> Midway height of the back of your head |
| <input type="checkbox"/> Lower height of the back of your head | <input type="checkbox"/> Located at the level of your neck      |
| <input type="checkbox"/> Level of your shoulder blades         |   |

### BRUISING AFTER THE CRASH

YES NO

<input type="checkbox"/>	<input type="checkbox"/>	Did your body have any bruising (areas that were visibly black, red, and/or blue) after the crash? If yes, indicate where bruising was located on your body and what caused the bruising:
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### AWARENESS AND BODY POSITION DESCRIPTIONS: *Check all areas that apply to you.*

<input type="checkbox"/>	You were unaware of the impending collision. You did not see or hear brakes prior to the impact.
<input type="checkbox"/>	You were aware of the impending crash and relaxed before the collision.
<input type="checkbox"/>	You were aware of the impending crash and braced yourself.
<input type="checkbox"/>	Your body, torso, and head were facing straight ahead.
<input type="checkbox"/>	You had your head and/or torso turned at the time of collision: <input type="checkbox"/> Turned to left, <input type="checkbox"/> Turned to right Describe how far you were turned/twisted and why you were turned/what were you doing?
<input type="checkbox"/>	You were leaning forward at the time of impact resulting in a gap between your body and the seatback If yes, indicate how far you were leaning and why you were leaning forward?
<input type="checkbox"/>	Your torso and body was positioned normally against the seatback with no gaps due to leaning/twisting

### HOW SOON DID YOU FIRST NOTICE ANY PAIN/SORENESS AFTER THE CRASH?

<input type="checkbox"/>	Immediately	<input type="checkbox"/>	About 1 hour later	<input type="checkbox"/>	6-12 hours later
<input type="checkbox"/>	The next morning	<input type="checkbox"/>	2 days later	<input type="checkbox"/>	Other:

# POST-TRAUMATIC SYMPTOM QUESTIONNAIRE

**PATIENT INSTRUCTIONS:** It is important for this section to be filled out in detail. Look at each symptom listed in the left column and make a single check mark or several check marks in the appropriate columns for the specific symptom which applies to you. Be certain to indicate when you had the beginning of any of the following symptoms. Leave the row blank if the symptom listed below does not apply to you.

<b>SYMPTOM LIST</b> (Check all that apply to you)	<b>BEGAN IN LESS THAN 24 HOURS AFTER INJURY</b>	<b>BEGAN 1 TO 7 DAYS AFTER INJURY</b>	<b>YOU HAVE SYMPTOMS RECENTLY</b>	<b>HAD SIMILAR SYMPTOMS ONE YEAR BEFORE THIS INJURY</b>
Headache/migraine				
Dizziness				
Tinnitus (ear ringing)				
Blurry vision				
Memory problems				
Poor concentration				
Irritability				
Balance problems				
Loss of coordination				
Sensitivity to sound				
Sensitivity to light				
Fatigue				
Anxiety				
Pain/difficulty swallowing				
Jaw pain/soreness				
Neck pain/soreness/aching				
Neck stiffness				
Shoulder pain/stiffness				
Arm pain/tingling/numbness				
Wrist/hand/finger pain/numbness				
Weakness in arms/legs				
Upper/middle back pain/soreness				
Rib cage pain/soreness				
Breast pain and/or bruising				
Low back pain/soreness/aching				
Hip pain				
Leg pain				
Leg numbness/tingling				
Pain down back of leg(s)				
Pain primarily in front of thigh(s)				
Knee pain				
Ankle/foot pain				
Other				