ARCHER FAMILY WELLNESS CLINIC
Donna Maria Archer, DC

MOTOR VEHICLE ACCIDENT QUESTIONAIRE

Patient Name: ______________________ Date: ______________
Home Phone: ____________ Cell: ____________ Work: ______________
Address: ______________________ City, State, Zip: ______________
E-mail: ______________________ Date of Birth: ______________
Driver's Lic. #: ____________ ST: ______ Social Security #: ______________
Date of Accident: ______________________ Place: ______________
Your Attorney: ______________________ Phone: ______________
Was this an on-the-job injury? Y N Explain: ______________________

Employer: ______________________ Phone: ______________
Address: ______________________

INFORMATION FOR VEHICLE YOU WERE RIDING IN:

Driver: ______________________ Phone: ______________
Owner: ______________________ Phone: ______________
Address: ______________________
Insurance Co: ______________________ Claim #: ______________
Adjuster Name: ______________________ Phone: ______________
Address: ______________________
Uninsured / Underinsured Motorist Insurance (UM / UIM)? Yes No
Personal Injury Protection? Yes No

INFORMATION FOR OTHER VEHICLE:

Driver: ______________________ Phone: ______________
Owner: ______________________ Phone: ______________
Address: ______________________
Insurance Co: ______________________ Claim #: ______________
Adjuster Name: ______________________ Phone: ______________
Address: ______________________

Who has been determined to be at fault? ______________________

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Name: Date:

ABOUT THE COLLISION

1 Were you the driver? Yes No
2 Were you alone in the vehicle? Yes No
3 List names of occupants in vehicle: ____________________

____

____

4 If you weren't the driver, where were you seated? ____________________
5 Time of Accident: ____________________
6 Weather: Wet Dry Rainy Snow Ice Other: ____________________
7 Headlights were: On Off
8 Wipers: On Off
9 Road Surface: Asphalt Concrete Dirt Gravel Other: ____________________
10 Road Terrain: Level Sloped Upward Sloped Downward
11 Road Design: Straight Curved Intersection
12 Traffic Control: Traffic Light Stop Sign None Other: ____________________
13 Was an Accident Report Made? Yes No
If yes, who made the report? ____________________
14 Identify any law enforcement agencies who came to the scene?

____

INFORMATION ON VEHICLE YOU WERE RIDING IN:

1 Year: __________ Make: __________ Model: __________
2 Where is the vehicle now? ____________________

____

3 Body type: 2 door 4 door Convertible SUV
Pickup Van Other: ____________________
4 Was vehicle carrying any extra weight? Yes No
Explain: ____________________
5 Transmission: Automatic Stick
6 Do you know damage estimate? Yes No Amount: $ ____________________
7 Were pictures taken of vehicle? Yes No
By Whom? ____________________

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Name: Date:

INFORMATION ON OTHER VEHICLE:

1 Year: ________ Make: ________ Model: ________

2 Body type: 2 door 4 door Convertible SUV
Pickup Van Other: ________

3 Was vehicle carrying any extra weight? Yes No
Explain: ________

4 Do you know damage estimate? ________

ACCIDENT INFORMATION:

1 Were you wearing a seat belt? Yes No
Lap and shoulder Lap only Shoulder only None

2 If you were using the shoulder belt, how was it positioned?
Neck Upper chest Other: ________

3 Did you adjust the headrest? Yes No Not adjustable No Headrest

4 The headrest was where in relation to the center of your head?
Above Below Center Not Sure

5 How far behind your head was the headrest?
In Contact Under 1 inch Over 1 inch Not Sure

6 Do you recall your head striking the headrest? Yes No

7 How was your seat positioned at time of impact?
Tilted back Tilted forward Upright

8 Did your seat change position upon impact? Yes No Not sure
If yes, was it: Tilted back Tilted forward Upright

9 Did your seat back: Break Bend Release failed to hold Not sure

10 Airbags: None Did not deploy Deployed

11 Were you hit by the airbag? Yes No Not sure
If yes, where were you hit? Face Arms Body Legs

12 Did the airbag cause injury to you? Yes No Not sure
If yes, where were you injured? Face Arms Body Legs
Other: ________

____

____

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COLLISION DYNAMICS

1 From what direction was your vehicle struck? Front Back Right Left
2 Was impact direct or at an angle? Direct Angled Describe: ____________________
____
3 Did your vehicle move after impact? Yes No Not sure
Describe: ____
4 How far apart were vehicles after impact? In contact Several feet Over 10 feet
5 Did driver brake after impact? Yes No Not sure
6 Was vehicle moving at impact? Yes No Estimate of speed: ______________
7 Was there visible damage to the vehicle you were riding in? Yes No
Describe: ____
8 What did you hear or see immediately before and during the collision?
____
9 Did any witnesses identify themselves? Yes No
Names:

BODY POSITION AND IMPACT

1 How was your head positioned at time of impact?
Straight ahead Turned left Turned Right Tilted up Tilted down Not sure
2 How were you sitting at time of impact?
Upright Leaning Forward Leaning Back Leaning Right Leaning Left Not sure
3 Were you holding the steering wheel at impact? Yes No Not sure Not driver
4 If you were driving, where were your hands? Left:___________ Right: ______________
5 Were you aware that the collision was about to occur? Yes No
6 Did you have time to brace? Yes No Describe: ____________________
____
7 Were you wearing glasses or a hat? Yes No
If yes, where were they after accident? ____________________
8 Did any objects within the vehicle (including trunk) move? Yes No
Describe: ____
9 Did your body strike anything inside the vehicle? Yes No
Describe: ____
10 Any cuts, scrapes or bruises from impact within vehicle? Yes No
Describe: ____
11 Any windows break? Yes No If yes, were you cut as a result? Yes No

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Name: Date:

INJURIES AND MEDICAL TREATMENT

1 When did you first become aware that you were injured?
Immediately Within___ minutes Within___ hours ___Days ___Weeks
2 What was the first injury you noticed? ______________________

____
3 Did you lose consciousness? Yes No Not sure How long? ______________
4 Circle any areas where you suffered cuts, bruises, scrapes or swelling: Head
Neck Shoulder R / L Arm R / L Back Chest Leg R / L Knee R / L Ankle R/L
5 Were you treated at scene? Yes No Paramedics Ambulance crew Other
6 Were you transported to hospital or clinic? Yes No
How? ______________ Where? ______________
7 For what conditions were you treated? ______________________

____
8 Were X-rays, MRI or CT scans performed? Yes No
9 Have you been examined by and/or treated by any other doctors, chiropractors, physical therapists, massage therapists, etc., since the collision? Yes No
List: ______________________

____
10 For what conditions were you treated? ______________________

____
11 Were x-rays, MRI or CT scans performed? Yes No
12 If you did not seek medical treatment within one week explain why? ______________

____
13 Have you had any pain tingling or numbness anywhere since the accident? Yes No
Describe: ______________________

____
14 Have you had any dizziness, vision or balance problems since the accident? Yes No
Describe: ______________________

____
15 Have you had any jaw pain since accident? Yes No
16 Have you had any jaw popping or trouble eating/chewing since the accident? Yes No
17 Have you had headaches? Yes No If yes, describe frequency, severity & sensation:

____
18 Have you had neck pain? Yes No Describe: ______________
19 Have you had back pain? Yes No Describe: ______________

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Name: ______________________________ Date: ______________

20 Have you unable to work since accident? Yes No How long? ______________
21 Did you have a doctor's release from work? Yes No Doctor: ______________
22 Your occupation: ______________
23 Have you noticed any pain or difficulty performing any of the following activities since the accident?

Reaching forward	Sitting	Stooping	Lifting up to 10 lbs.
Reaching down	Bending	Kneeling	Lifting 10 - 20 lbs.
Reaching up	Pushing	Crouching	Lifting 20 - 50 lbs.
Handling small items	Pulling	Crawling	Lifting repetitively
Pouring coffee/milk	Walking	Climbing	Tasting/Smelling
Keyboarding	Stuttering	Yawning	Comprehension
Word choices	Talking	Hearing	Seeing close up
Depth perception	Chewing	Vision	Seeing far away
Difficulty following conversation		Confusion or stress with loud noises	
Confusion or stress in "Busy" places (mall, restaurants, etc.)			

24 What leisure, social or domestic activities have you had to avoid?
____
____

PAST MEDICAL HISTORY

1 Have you suffered an injury to your head, neck or back in the past? Yes No
Explain area and how injured: ______________________________
____
2 Have you made a personal injury or workers compensation claim in the past? Yes No
Explain: ______________________________
3 Have you been treated by a health care professional for head, neck or back pain? Yes No
Explain: ______________________________
4 Have you received physical therapy for any condition? Yes No
Explain: ______________________________
5 Did you have any physical complaints before this accident? Yes No
Explain: ______________________________
____

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Name: ______________________________ Date: ______________

ADDITIONAL COMMENTS:

____

____

____

____

____

____

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____

____

PLEASE DRAW A PICTURE OF THE ACCIDENT SCENE:

Label the vehicle you were riding in "A" and the other vehicle(s) "B" "C" "D" etc.

Label streets and landmarks clearly and use arrows to show direction vehicles were traveling.

N
W + E
S

Completed By: ______________________________ Date: ______________

Reviewed By: ______________________________ Date: ______________

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