MOTOR VEHICLE COLLISION/PERSONAL INJURY QUESTIONNAIRE

Please answer all questions completely:

1. Your name and address:

   _____

   _____

   _____

2. Phone Number: _____

3. Please describe the collision in your own words:

   _____

   _____

   _____

4. Where did the collision occur? City/Town: _____ State: _____
5. Date of collision: _____ Time: _____ AM PM
6. Were you the: ☐ driver ☐ passenger ☐ pedestrian
7. If passenger, were you in the ☐ front seat ☐ right rear seat ☐ left rear seat
8. What type of vehicle were you in? _____
9. What type was the other vehicle? _____
10. Did your vehicle strike the other vehicle? ☐ yes ☐ no
11. Was your car struck by the other vehicle? ☐ yes ☐ no
12. What direction was your vehicle going? _____
13. What direction was the other vehicle going? _____
14. Was the impact from: ☐ the front ☐ the rear ☐ the left side ☐ the right side
15. What was the approximate speed at the time of the impact?

    Your vehicle _____ mph Other vehicle _____ mph
16. What was the weather at the time of the collision? ☐ dry ☐ wet ☐ icy
17. Was your vehicle in: ☐ park ☐ neutral ☐ in gear ☐ moving ☐ stopped
18. Were your brakes being applied? ☐ yes ☐ no
19. Was your vehicle shoved: ☐ forward ☐ backward ☐ sideways
20. Were you shoved: ☐ forward ☐ whipped backward
21. Did your seat have a head restraint (headrest?) ☐ yes ☐ no

20. Did you have x-rays taken at the hospital? ☐ Yes ☐ No

21. Are you diabetic? ☐ Yes ☐ No

22. Do you have high blood pressure? ☐ Yes ☐ No

23. Do you have arthritis or degenerative joint disease? ☐ Yes ☐ No

24. List all prescription and non prescription medications you take on a regular basis:

_____

_____

25. Are you presently under treatment for any condition? ☐ Yes ☐ No _____

26. Who is your primary care doctor: name, address and phone: _____

_____

27. Do You Smoke? ☐ Yes ☐ No Drink Alcohol? ☐ Yes ☐ No

28. Did you have any physical complaints **Just before the injury?** ☐ Yes ☐ No

29. If yes, what physical symptoms did you have **just before the injury?** _____

_____

30. What type of work do you do? _____

31. What are your job requirements? _____

32. Have you lost any days of work because of this injury? ☐ Yes ☐ No

33. If yes, give dates: _____

ACTIVITIES OF DAILY LIVING

34. Do you notice any of your **HOME** activities that are different **now** from than **before** the injury? ☐ No. If YES, list them as: (please be very specific)

Those activities that you are now unable to do are: _____

_____

Those activities that are now painful to do are: _____

_____

Those activities that are now difficult to do are: _____

_____

Is there anything else we should know? _____

_____

Patient Signature _____ Date _____

Print Name _____

22. If yes, what was the position ☐ low ☐ midposition ☐ high
23. Did your head ride over the headrest? ☐ yes ☐ no
24. Did your hat/glasses end up in the back seat or rear window? ☐ yes ☐ no
25. Did any other part of your body hit the interior of the vehicle? ☐ yes ☐ no
26. If yes, please specify: ☐ seatbelt restraints ☐ steering wheel ☐ dashboard ☐ windshield ☐ side door ☐ side window ☐ other _____
27. Which part of your body? ☐ chest ☐ head ☐ chin ☐ face ☐ R L knee ☐ R L shoulder ☐ R L hand ☐ other _____
28. Were you holding on to the steering wheel? ☐ yes ☐ no
29. Did you brace your arms against the dash? ☐ yes ☐ no
30. Did you brace your legs against the floorboard? ☐ yes ☐ no
31. Was your ankle turned? ☐ yes ☐ no
32. Did the vehicle go into a spin or roll as a result of the impact? ☐ yes ☐ no
33. If yes, explain: _____
34. How much damage was there to the outside of the vehicle? ☐ none ☐ some ☐ a lot
35. How much damage was there to the inside of the vehicle? ☐ none ☐ some ☐ a lot
36. At the point of impact, where did you experience pain? Be specific:

_____

_____

37. Immediately after the accident were you: ☐ conscious ☐ dazed ☐ unconscious
38. If you lost consciousness, how long? _____
39. Were you wearing a seat belt? ☐ yes ☐ no
40. Did the belt have a shoulder harness? ☐ yes ☐ no
41. If yes, did it contribute to the pain you are experiencing? ☐ yes ☐ no
42. At the time of impact were you: ☐ looking straight ahead ☐ looking to the right ☐ looking to the left ☐ looking down ☐ looking up
43. Did the seat break as a result of the impact? ☐ yes ☐ no
44. Were you braced for the impact? ☐ yes ☐ no
45. Were you surprised by the impact? ☐ yes ☐ no
46. Did you go to the hospital? ☐ yes ☐ no
47. If yes, when? ☐ right after the accident ☐ next day ☐ other _____

48. If yes, how did you get there? ☐ ambulance other: _____

49. If by ambulance, did the ambulance attendants place you in a: ☐ neck brace ☐ back brace ☐ other _____

50. Any medication or medical supplies given? _____

51. Did you have x-rays taken at the hospital? ☐ yes ☐ no

If you went to the hospital, please answer the following:

Name of hospital _____

Name of doctor _____

Diagnosis _____

Treatment Received _____

_____

52. Have you had any similar problems before? ☐ yes ☐ no

53. If yes, explain: _____

54. Are you diabetic? ☐ yes ☐ no

55. Do you have high blood pressure? ☐ yes ☐ no

56. Do you have low blood pressure? ☐ yes ☐ no

57. Do you have arthritis or degenerative joint disease ☐ yes ☐ no

58. What type of work do you do? _____

59. What are your job requirements? _____

60. Have you lost any days of work from this injury? ☐ yes ☐ no

61. If yes, give dates: _____

Patient Signature _____ Date _____

Witness _____ Date _____

Print Name _____

McCarter Health Center Personal Injury Waiver

Thank you for choosing McCarter Health Center for treatment of your personal automobile injury. You will possibly be scheduled with multiple providers during your course of treatment at our facility. These treatments could include chiropractic, manual massage therapy, physical therapy, and cold laser therapies. If you are unable to make your appointment(s) then we kindly ask for you to call 24 hours prior to reschedule your appointments. If you do not call ahead you will be charged a $50 no show fee for physical therapy and chiropractic/massage therapy for each missed appointment. By calling ahead to reschedule your appointments allows others to make appointments that they need in your canceled appointment time.

Thank you,

Dr. Heather McCarter
McCarter Health Center

Patient Signature:_____

Patient Printed:_____ Date:_____

Please email completed form to info@mccarterhealthcenter.com
Or fax to 304-428-5087