New Patient Packet

Patient Name:_____

Motor Vehicle Accident Supplemental Questionnaire

Date of Accident: _____ Were you the: ☐ Driver ☐ Passenger

If you were the passenger where in the car were you sitting:

☐ Right Front Seat ☐ Left Rear Seat ☐ Middle Rear Seat ☐ Right Rear Seat

Approximately what time did the accident occur? _____ ☐ AM or ☐ PM

What were the driving conditions like? (i.e. dry, sunny, dark,rainy, snowy, icy, etc)_____

Were you wearing a seatbelt? Y / N

If yes, which kind of seatbelt were you wearing? ☐ Lap-belt ☐ Shoulder and lap-belt

Was the vehicle: ☐ Stopped at a stop light/sign ☐ Stopped in traffic ☐ Traveling in traffic

What was the make and model of the vehicle you were in?

Make:_____ Model:_____

Did the airbags deploy? Y / N

Did you hit your head or lose consciousness? Y / N

If yes, did you have any? (please mark all that apply): ☐ Cuts ☐ Bumps ☐ Bruises

At impact which direction were you facing? ☐ Forward ☐ Turned to the left ☐ Turned to the right

Were the police at the scene of the accident? Y / N

Was the fire department at the scene of the accident? Y / N

Was an ambulance at the scene of the accident? Y / N

If yes, were you taken to the hospital via ambulance? Y / N

Patient Name:_____

If yes, which hospital were you taken to? _____

What were the estimated damages to the vehicle you were in?_____

Post-accident what was the status of the following (please mark all that apply):

Exercise Level: Unlimited None Other_____

Work Level: Unlimited None Other_____

Activities of daily living: Unlimited None Other_____

Overall progression of symptoms: Improving ☐ Stable ☐ Worsening ☐

Please describe what happened at the time of the accident to the best of your ability.

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_____

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_____

Patient Name: _____
Print Name Signature Date

- OR -

Patient Representative: _____
Print Name & Relationship to Patient Signature Date