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MOTOR VEHICLE COLLISION 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?

16: Your vehicle _____ mph? Other vehicle _____ mph?

17: What was the weather at the time of the collision? ____dry ____wet ____icy

18: Was your vehicle in: ____park ____neutral ____in gear ____moving ____stopped

19: Were your brakes being applied? ____yes ____no

20: Was your vehicle shoved: ____forward ____backward ____sideways

21: Were you shoved: ____forward ____whipped backward

22: Did your seat have a head restraint (headrest?) ____yes ____no

Patient Name: _____ Date: _____

23: If yes, what was the position ____low ____mid-position ____high

24: Did your head ride over the headrest? ____yes ____no

25: Did your hat/glasses end up in the back seat or rear window? ____yes ____no

26: Did any other part of your body hit the interior of the vehicle? ____yes ____no

27: If yes, please specify: ____seatbelt restraints ____steering wheel ____dashboard ____windshield ____side door ____side window ____other _____

28: Which part of your body? ____chest ____head ____chin ____face ____R L knee ____R L shoulder ____R L hand ____other _____

29: Were you holding on to the steering wheel? ____yes ____no

30: Did you brace your arms against the dash? ____yes ____no

31: Did you brace your legs against the floorboard? ____yes ____no

32: Was your ankle turned? ____yes ____no

33: Did the vehicle go into a spin or roll as a result of the impact? ____yes ____no

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

If yes, did it contribute to the pain you are experiencing? ____yes ____no

41: At the time of impact were you: ____looking straight ahead ____looking to the right ____looking to the left ____looking down ____looking up

42: Did the seat break as a result of the impact? ____yes ____no

43: Were you braced for the impact? ____yes ____no

44: Were you surprised by the impact? ____yes ____no

45: Did you go to the hospital? ____yes ____no

46: If yes, when? ____right after the accident ____next day ____other _____

47: If yes, how did you get there? ____ambulance other: _____

48: If by ambulance, did the ambulance attendants place you in a: ____neck brace ____back brace other _____

49: Any medication or medical supplies given? _____

50: Did you have x-rays taken at the hospital? ____yes ____no

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

Name of hospital _____

Treatment Received _____

52: Have you had any similar problems before? ____yes ____no

If yes, explain: _____

53: Are you diabetic? ____yes ____no

54: Do you have high blood pressure? ____yes ____no

55: Do you have low blood pressure? ____yes ____no

56: Do you have arthritis or degenerative joint disease? ____yes ____no

57: What type of work do you do? _____

58: What are your job requirements? _____

59: Have you lost any days of work from this injury? ____yes ____no

If yes, give dates: _____

60. Was anyone else in the vehicle with you? _____

Patient Name: _____ Date: _____

Doctor Signature: _____ Date: _____

Doctor Reviewed with Patient _____

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Functional Loss
Permanent Losses and Duties Under Duress

Permanent loss indicates what can no longer performed after a reasonable course of care has concluded and duties under duress indicates what you can still do, but causes pain and/or limitations

Name:_____ Date:_____

Employment

Activity	Reason for Difficulty	Please choose one: unable to perform or a date range
Lifting: ☐	Increased Pain ☐ Restricted Movement ☐ Weakness	☐ Unable to Perform since Accident From: To:
Bending: ☐	Increased Pain ☐ Restricted Movement ☐ Weakness	☐ Unable to Perform since Accident From: To:
Sitting: ☐	Increased Pain ☐ Restricted Movement ☐ Weakness	☐ Unable to Perform since Accident From: To:
Walking: ☐	Increased Pain ☐ Restricted Movement ☐ Weakness	☐ Unable to Perform since Accident From: To:
Carrying: ☐	Increased Pain ☐ Restricted Movement ☐ Weakness	☐ Unable to Perform since Accident From: To:
Computer: ☐	Increased Pain ☐ Restricted Movement ☐ Weakness	☐ Unable to Perform since Accident From: To:

Specific Activities/Duties are asked on a seperate page

Loss of: Job ☐ Chance of raise ☐ Job status ☐ Promotion ☐

On a separate piece of paper, please explain in detail your job description and what changed, or what you can no longer do that you could do before your accident.

Restrictions within your home

Activity	Reason for Difficulty	Please choose one: unable to perform or a date range
Lifting: ☐	Increased Pain ☐ Restricted Movement ☐ Weakness	☐ Unable to Perform since Accident From: To:
Bending: ☐	Increased Pain ☐ Restricted Movement ☐ Weakness	☐ Unable to Perform since Accident From: To:
Sitting: ☐	Increased Pain ☐ Restricted Movement ☐ Weakness	☐ Unable to Perform since Accident From: To:
Walking: ☐	Increased Pain ☐ Restricted Movement ☐ Weakness	☐ Unable to Perform since Accident From: To:
Carrying: ☐	Increased Pain ☐ Restricted Movement ☐ Weakness	☐ Unable to Perform since Accident From: To:
Computer: ☐	Increased Pain ☐ Restricted Movement ☐ Weakness	☐ Unable to Perform since Accident From: To:

Specific Activities/Duties are asked on a seperate page

On page 3 and 4, please explain in detail your job description and what changed, or what you can no longer do that you could do before your accident.

Restrictions outside your home

Activity	Reason for Difficulty	Please choose one: unable to perform or a date range
Lifting: ☐	Increased Pain ☐ Restricted Movement ☐ Weakness	☐ Unable to Perform since Accident From: To:
Bending: ☐	Increased Pain ☐ Restricted Movement ☐ Weakness	☐ Unable to Perform since Accident From: To:
Sitting: ☐	Increased Pain ☐ Restricted Movement ☐ Weakness	☐ Unable to Perform since Accident From: To:
Walking: ☐	Increased Pain ☐ Restricted Movement ☐ Weakness	☐ Unable to Perform since Accident From: To:
Carrying: ☐	Increased Pain ☐ Restricted Movement ☐ Weakness	☐ Unable to Perform since Accident From: To:
Yard work: ☐	Increased Pain ☐ Restricted Movement ☐ Weakness	☐ Unable to Perform since Accident From: To:

Specific Activities/Duties are asked on a seperate page

On page 3 and 4, please explain in detail your job description and what changed, or what you can no longer do that you could do before your accident.

Recreational sports and activites

Activity	Reason for Difficulty	Please choose one: unable to perform or a date range
Lifting: ☐	Increased Pain ☐ Restricted Movement ☐ Weakness	☐ Unable to Perform since Accident From: To:
Bending: ☐	Increased Pain ☐ Restricted Movement ☐ Weakness	☐ Unable to Perform since Accident From: To:
Sitting: ☐	Increased Pain ☐ Restricted Movement ☐ Weakness	☐ Unable to Perform since Accident From: To:
Walking: ☐	Increased Pain ☐ Restricted Movement ☐ Weakness	☐ Unable to Perform since Accident From: To:
Carrying: ☐	Increased Pain ☐ Restricted Movement ☐ Weakness	☐ Unable to Perform since Accident From: To:
Physical Activity: ☐	Increased Pain ☐ Restricted Movement ☐ Weakness	☐ Unable to Perform since Accident From: To:

Specific Activities/Duties are asked on a seperate page

On page 3 and 4, please explain in detail your job description and what changed, or what you can no longer do that you could do before your accident.

School | Educational

Activity	Reason for Difficulty	Please choose one: unable to perform or a date range
Lifting: ☐	Increased Pain ☐ Restricted Movement ☐ Weakness	☐ Unable to Perform since Accident From: To:
Bending: ☐	Increased Pain ☐ Restricted Movement ☐ Weakness	☐ Unable to Perform since Accident From: To:
Sitting: ☐	Increased Pain ☐ Restricted Movement ☐ Weakness	☐ Unable to Perform since Accident From: To:
Walking: ☐	Increased Pain ☐ Restricted Movement ☐ Weakness	☐ Unable to Perform since Accident From: To:
Carrying: ☐	Increased Pain ☐ Restricted Movement ☐ Weakness	☐ Unable to Perform since Accident From: To:
Computer: ☐	Increased Pain ☐ Restricted Movement ☐ Weakness	☐ Unable to Perform since Accident From: To:

Specific Activities/Duties are asked on a seperate page

On page 3 and 4, please explain in detail your job description and what changed, or what you can no longer do that you could do before your accident.

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On the next page, please write 10 separate statements about what both can no longer do and what you can, but is done with pain, or under duress.

The following are samples to help guide you:

Name:_____Date:_____

Work Limitations: "I am an automobile mechanic. I can't lean over the car for a long period of time. When I use my right hand to hold tools for a long period of time I get pain that shoots up to my neck and down to my lower back. I have to stop from time to time and rest so it's hard to finish repairs in a timely manner Therefore I had to change my job from a full time mechanic to a part time mechanic and a part time service writer reducing my pay by 30%."

Work Limitations Due to Pain: I was a full time employee at Mr. Fixit and my duties are being a mechanic. Since the accident I have resumed my job with lighter duties and less hours. Since the accident I have lost my status, job security, promotional prospects and my quality of work has lessened due to the pain.

Inside Domestic Permanent Losses: "I have become very agitated. I can no longer pick up my infant daughter. When I wake up in the morning I have neck and back pain. I can't reach over my head or stretch my legs. There are times when I feel like I'm being stabbed in the back. I can no longer carry groceries fro the car to my kitchen and I am unable to vacuum. I am also having difficulty during sexual relations due to the pain in my neck and back."

Inside Domestic Limitations Due to Pain: "I have lost enjoyment when performing my domestic activities due to the pain in my neck as a result of the injury. I have experienced a loss of enjoyment with the following activities inside my home: laundry, dishwashing, washing windows, cleaning and preparing meals, which I do with pain and to a much lesser extent. As a result I no longer enjoy these duties as I did before my accident."

Outside Household Permanent Losses: I can no longer paint the house, weed the garden, mow the lawn, wash the car, repair broken shingles, shovel snow or maintain the lawn as I did before the accident due to the pain in my neck and back.

Outside Household Limitations Due to Pain: "I have experienced a loss of enjoyment with the following activities outside my home: landscaping, trimming bushes, washing windows, gardening and taking out the trash since the accident due to the pain in my neck and back."

Social Permanent Limitations: "When I go to the movies or concerts I can't enjoy them because I can't sit for long periods of time without pain so I do not go. I tried to play touch football and shoot basketballs as I did prior to the accident, but I have difficulty due to my neck and back pain and limitations with my arm and can no longer play."

Social Limitations Due to Pain: "I can only walk for 30 minutes, where before the accident I could walk for 2-3 hours. I have a fear when driving in the car. Whenever I hear a horn or screeching brakes I am afraid I'm going to get hit again so I drive in the right lane very slow."

Education/School Permanent Losses: I was enrolled part time in college and due to the pain as a result of the accident I can no longer sit in class, therefore I had to drop out of school and enroll in an online program.

Education/School Limitations Due to Pain: I have experienced a loss of enjoyment when performing the following educational activities as a result of the injury. I am attending an Online college degree program and I have dropped to part time and have been getting lower grades. This is problematic as I am on a degree tract that will now take much longer and my prospect for advancement has significantly diminished with lower grades.

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Name:_____Date:_____

Using the guide above, please complete the following about what YOU can either no longer do, or can do under duress (with pain:)

1. Work Limitations:

2. Work Limitations Due to Pain:

3. Inside Domestic Permanent Losses:

4. Inside Domestic Limitations Due to Pain:

5. Outside Household Permanent Losses:

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Name:_____Date:_____

6. Outside Household Limitations Due to Pain:

7. Social Permanent Limitations:

8. Social Limitations Due to Pain:

9. Education/School Permanent Losses:

10. Limitations or loss of sex life:

It is medically and legally important to document how the accident has altered this aspect of your life. If the accident has negatively affected your sex life please describe in generalities how so.

The Rivermead Post Concussion Symptoms Questionnaire

After a head injury or accident some people experience symptoms which can cause worry or nuisance. We would like to know if you now suffer any of the symptoms given below. As many of these symptoms occur normally, we would like you to *compare yourself now with before the accident.* For each one please circle the number closest to your answer.

0=Not experienced at all
1=no more of a problem now than before the accident
2=a mild problem now
3=a moderate problem now
4=a severe problem now

Compared with before the accident, do you now (i.e. over the last week) suffer from:

Headaches	0	1	2	3	4
Feelings of dizziness	0	1	2	3	4
Nausea and/or vomiting	0	1	2	3	4
Noise sensitivity, or easily upset by loud noise	0	1	2	3	4
Sleep disturbance	0	1	2	3	4
Fatigue, tiring more easily	0	1	2	3	4
Being irritable, easily angered	0	1	2	3	4
Feeling depressed or tearful	0	1	2	3	4
Feeling frustrated or impatient	0	1	2	3	4
Forgetfulness, poor memory	0	1	2	3	4
Poor Concentration	0	1	2	3	4
Taking longer to think	0	1	2	3	4
Blurred Vision	0	1	2	3	4
Light sensitivity, or easily upset or irritated by bright light	0	1	2	3	4
Double Vision	0	1	2	3	4
Restlessness	0	1	2	3	4

Are you experiencing any other difficulties? Some other symptoms of Post concussion syndrome include the following: Reading problems, writing problems (writing the wrong letter first), typing problems, inability to remember ATM or other numbers, attention impairment, personality changes, intolerance to heat, intolerance to cold, intolerance to alcohol, and loss of sex drive/libido. Please specify any of these additional problems you experience, and rate as above:

1_____	0	1	2	3	4
2._____	0	1	2	3	4
3._____	0	1	2	3	4
4._____	0	1	2	3	4

Full Name_____Signature_____Date_____