**Motor Vehicle Collision Questionnaire**

Name:_____ Today's Date:_____

Date of Birth:_____ Date of Accident:_____

Location of accident:_____

Were you Driver, Passenger, or Pedestrian? (circle one) Number of vehicles involved:_____

Speed of impact: _____ Wearing seatbelt? Yes/No Did airbags deploy? Yes/No

Type of car you were in (sedan, SUV, etc.):_____

Type of car other(s) were driving:_____

Describe accident & Nature of impact (rear-end, side-swipe, etc.):_____

_____

_____

Damage to vehicles:_____

Body region and severity of injuries:_____

Taken to hospital? Where?_____

Hospitalized? How long?_____

X-Rays / CT Scan, etc. done?_____

**Current Condition:**
Location(s) of pain_____

Severity of pain from 1-10: on average day_____ at worst_____

Pain medication:_____

Other treatments (Physical Therapy, Chiropractic, Massage, etc.)

Car Insurance(s) involved: (yours)_____(others)_____

Claim Number:_____

Adjuster Name & Phone/Fax:_____

Physician's Notes: