MOTOR VEHICLE COLLISION QUESTIONNAIRE

Name _____ Date _____

1. Date of Accident _____
2. Were you driving YES NO
   If NO, where were you seated?
   _____
3. Year and model of vehicle
   _____
4. How fast were you going?_____ km/hr or stopped
5. Were seat belts worn? YES NO
6. Did airbags deploy? YES NO
7. Where was YOUR vehicle struck? (Check all that apply)
   Passenger's side Driver's side Rear Front Other _____
8. Type of accident : Head-on Broad-side T-bone Rear-end Non-collision
9. Did you see the accident coming? YES NO
10. Describe in your own words what happened to YOU upon impact:
    _____
    _____
    _____
    _____
    _____
11. At time of accident, do you recall what parts of your head/body hit what parts on the inside of your vehicle?
    _____
    _____
12. What was approximate damage to the vehicle
    _____
13. Did you lose consciousness? YES NO
14. Were you able to get out of the car and walk unaided? YES NO
    If NO, why?
    _____
15. Describe any cuts or bruises from the accident if applicable
    _____
    _____
    _____
16. Please described how you felt:
    a. Immediately after the accident:
       _____

b. Later that day:
_____

c. The next day:
_____

17. Were you assessed by medical personnel at the scene? YES NO

18. Did you seek medical help immediately after? YES (continue) NO (go to #26)
19. Where did you go?
_____
20. How did you get there? Ambulance Police Drove Own Car Someone Else Drove Me Other
_____
21. Who was the doctor that assessed you?
_____
22. Were X-Rays taken? Yes No
23. At what facility?_____
24. Did you receive treatment/meds? YES NO
25. If yes, what kind of treatment/meds did you receive?
_____
26. Have you seen any other doctors/family physician? Yes (continue) No (go to #40)
27. Doctor #2: Name
_____
28. First Visit Date
_____
29. Were you examined? YES NO
30. Were X-Rays taken? YES NO
31. At what facility?
_____
32. Did you receive treatment/meds? YES NO
33. If yes, what kind of treatment/meds did you receive?
_____
34. Have you seen any other doctors? YES – Name: _____ No (go to #40)
35. First Visit Date
_____
36. Were you examined? YES NO
37. Were X-Rays, CT scan, MRI taken? YES NO
38. At what facility?
_____
39. Did you receive treatment/meds? YES NO
40. If yes, what kind of treatment/x-rays/meds did you receive?
_____

41. What is your occupation?
_____
42. Your employer?
_____
43. Have you missed time from work? YES NO
44. Do you have an attorney for this claim? YES NO
45. If yes, Name:
_____
Address:
_____
City: _____ Phone:
_____
46. Do you have other benefits through an employer (Extended Health Care Benefits) that covers for physiotherapy? [ ] YES [ ] NO
If yes, please provide the name of your carrier
_____

Thank your for completing this form.