Bourque Chiropractic Clinic

17487 Old Jefferson Hwy Ste D Prairieville, LA 70769

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: _______________

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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: _______________________

Patient Name: ____ Date: ________________

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: ____

Patient Name: ____ Date: _______________

_____ Doctor Reviewed with Patient

Doctor Signature: ___________________________________ Date:__________